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ABSTRACT

The aim of this conference was to consider current thinking on behavior modification and social education, and to examine ways in which the psychological and educational concepts and skills involved in these approaches could best be taught to nurses. Over 40 nurse tutors, clinical teachers, and inservice training officers attended the conference. Formal lectures were given by a sociologist and several psychologists working in university and health service settings. Participants also made short presentations of projects relevant to the theme of the conference. Major topics covered include: memory, hospital care, social education and normalization, behavior modification in hospitals and communities, reactions to an audiotaped teaching course, and the contribution of research to understanding of audiovisual media for teaching and training. (Author/JEG)

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EDUCATING THE TRAINERS

PROCEEDINGS

of a conference for nurse educationalists in mental handicap held at the University of Keele, April 21st - 23rd, 1978

Editors: J. R. Hegarty
S. P. Winter

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PREFACE

This book contains the edited Proceedings of a weekend conference at which over 40 nurse tutors, clinical teachers and in-service training officers met to discuss topics of mutual interest. Formal lectures were given by a sociologist and psychologists working in university and health service settings after each of which there were questions and discussions. In addition, participants gave short presentations of projects relevant to the theme of the conference.

The aim of the conference was to consider current thinking on behaviour modification and social education and to examine ways in which the psychological and educational concepts and skills involved in these approaches could best be taught to nurses.

At a time when the future role and training of mental handicap nursing staff is under discussion there is clearly a pressing need for nurse educationalists to meet and to review the content and presentation of training courses for care staff. Participants felt that this weekend offered an unusual and valuable opportunity to do this and hoped that future conferences of a similar kind would be organised in the near future.

In publishing the Conference Proceedings the organisers hope that others will be able to share not only in the lectures from experienced specialists that were given but also in the discussions which aired practical problems and issues.

John R. Hegarty
Sally P. Winter

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ASSISTING MEMORY

Professor I. M. L. Hunter

Department of Psychology, University of Keele, Staffordshire.

All of us here today are interested, one way or another, in problems of human learning and remembering. In touching briefly on such problems, I shall start by considering something which is, I am sure, unfamiliar to you - the message sticks of the Australian aborigines.

Australian aborigines live in desert country which stretches for hundreds of miles and is so inhospitable as to seem scarcely capable of supporting life. Yet the aborigines, with no written language and extremely few material possessions, manage to find food and water. They live in small groups which move from place to place. Groups meet up occasionally to exchange news and hold those ceremonies which importantly mark the main stages of their life. From time to time, groups send messages to each other. These messages are sent and received by older, senior members of the group, but carried by one of the young men. And this is where message sticks come in. Their use is indicated by the following (slightly edited) first-hand account.

"I assume that I am living at some place which is five camp stages distant from some friend to whom I wish to send the following message. 'I am here, five camps distant from you. In ten days time I will go and see you. There are eight people (naming them) camped here with me. Send me some flour, tea, sugar and tobacco. How are Bulkoin and his wife, and Bunda?' Having my messenger by me, I should then prepare a message stick, say a piece of wood, six inches long, half-an-inch wide."

"On the stick I should make the following marks. Five notches representing the five camp stages distant from the recipient of the message. Then a flat place cut in the edge to show a break in the message. Then ten notches representing the time in days after which the sender will visit his friend. Then eight notches representing the eight people camped with the sender. Then four notches representing the articles asked for. Then a flat place representing another break in the message. Three notches representing the people asked after. Having made these marks and explained them to my messenger, I should then carve the end of the stick to make it ornamental, and then give it to him for delivery."

Notice that the messenger has to carry much of the message in his head, or as the aborigines would say 'in his mouth'. Notice too that, while the marks represent key points of the message, they do so in an arbitrary, ad hoc way. Unlike written language, the marks have no conventionalized meaning which they retain outside the immediate context in which they are used. To be sure, when people have been in frequent communication with each other by means of message sticks and are accquainted generally with each other's concerns, it is sometimes possible for one of them to guess, with more or less certainty, at the meaning of any marked stick sent to him. But typically, a stick cannot be 'read' until it has been explained. Essentially, the stick functions as a memory-aid for the messenger and, subsequently, for the recipient.

The message stick serves as a memory-aid in two distinct ways. First, while listening to the message being given, the messenger is provided with an additional sensory context. He can relate the points of the message to the marks on the stick, and he can watch the sender make these marks to emphasize what is being said. Secondly, when the messenger later delivers the stick to the recipient, the marks serves as a framework which guides and prompts recall. Each mark stands for something, and helps to bring that something to mind. After the stick has been explained, the recipient keeps it to help him, in his turn, to retain the message for as long a time as need be.

What do the message sticks tell us about learning and remembering?

They nicely illustrate three general points. First, learning is aided by an appropriate supporting context. When we learn anything, we grasp it better if we relate it to other things. A supporting context can take many forms. Sometimes it is provided from outside, e.g. the vivid illustrative example of an abstractly made point, the telling visual aid, the marking on the message stick. Sometimes it is provided by our own interpretations and elaborations, e.g. a stranger's name is better learned if we notice that it is the same as that of someone we know well. Studies of people who have extraordinarily good memory show that they consistently interpret any new material by relating it to many other things they already know and, thereby, enmeshing it in an organized body of familiar knowledge. In the psychological literature, the term 'encoding' is used to refer to the processes of interpreting and elaborating new material. Suitable encoding, that is, the elaboration of appropriate supporting contexts, is a powerful aid to memory.

Secondly, recall is aided by the availability of appropriate prompts, or retrieval cues. When we try to recall something, we do so more easily and accurately in the presence of suitable retrieval cues. As with supporting contexts, retrieval cues can take many forms. Some come from outside, e.g. when we revisit a place we encounter cues which prompt us to recall the events we witnessed when we last visited that place. The message stick provides external prompts to recall. Sometimes, retrieval cues are provided by our own thoughts, as when we search our memory concerning some bygone event and find that the recall of one detail triggers the recall of another detail. Notice that, when we learn something by elaborating a rich supporting context for it, we lay down a host of potential retrieval cues which can later help us to recall it.

The third, and the most general, point illustrated by the message stick is that learning and remembering are activities of a problem-solving kind. We can set about them in various different ways, some of which are more likely to be successful than others. Suppose you have written a letter which you wish to put in the post next morning. You have a choice of things you might do to ensure you don't leave the house without it. You could place it by the front door where you would be sure to see it on the way out; think about the letter just before going to sleep; tie a string on your finger as a reminder; ask a member of the family to remind you; and so on. Here we have a problem, albeit a simple one, involving learning and remembering, and you can approach this problem in various ways, each of which has its own advantages and disadvantages. For the aborigines, the sending of messages from one group to another is too important an activity to be treated casually Given the absence of written language, the use of message sticks is an eminently sensible way of dealing with the problems of learning and remembering which are involved.

How we think about 'memory'.

What has just been said has important implications for the way we think about memory. In everyday life, we often use the word 'memory' to refer to some capacity which is relatively fixed and constant for any one individual person, but which varies between one person and another. According to such a view, some people are 'gifted with a good memory' while others are 'burdened with poor memory'. Now, this capacity conception of memory is undoubtedly correct, but only up to a point. What it fails to take into account is the problem-solving characteristics of memory. When we begin to consider, not memory in the abstract, but actual specific examples of what and how people learn and remember, we see 'memory' in a different light. We see that learning and remembering are activities which involve a host of sub-skills, procedures, and strategies which are capable of modification and improvement. Memory, in short, can be assisted by helping people to set about learning and remembering in ways which are more appropriate.

To drive home the point, suppose a child fails on some task of learning and remembering. Does this mean that 'his memory is too poor', that he is, in some absolute sense, incapable of succeeding with the task? Clearly not. It may well happen that he succeeds on this very task when he is given guidance in how to go about it. When this happens, we are forced to admit that his earlier failure is not adequately accounted for by 'poor memory'. Rather he has the sub-skills necessary for success, but does not select and sequence these sub-skills so as to deal effectively with the task. His 'poor memory' turns out to mean merely that he has been using inappropriate strategies.

To illustrate what has just been said, let me outline in some detail the results of a series of investigations reported by Butterfield, Wambold and Belmont (in The American Journal of Mental Deficiency, 1973, vol. 77, pages 654-669). In these investigations, children and adults, both normal and mentally retarded, were given a memory task of the following kind. The subject (S) faces an upright screen containing a horizontal row of small windows. In the first window, at the extreme left, a letter of alphabet appears for 0.5 sec., then vanishes. Then a second letter appears for 0.5 sec. in the next window along. Then a third letter in the third window, and so on until a succession of six letters has been shown. Then, in the seventh window, on the extreme right, one of the preceding letters appears once more. This is the 'probe letter' and S has now to press the window where that letter appeared earlier.

An important feature of this task is that, when each letter appears it remains exposed for an automatic 0.5 sec, but the onset of each letter is controlled by S himself, who pushes a button at the base of the panel in order to bring the letter on. Thus the task is paced by S himself.

A trial starts with the appearance of a black square in the left-most window. To see the first letter, S presses the control button which causes the black square to be replaced by the first letter for 0.5 sec. Then S must press the button again to see the second letter in the second window. And then again to see the third letter. And so on. An automatic record is kept of S's pace of working, e.g. the time between the disappearance of each letter and the next push-to-see, and between the appearance of the probe letter and S's pressing one of the windows. S attempts several such trials with different letter sequences, and with the 'correct' letter located in different windows.

In this memory task, adults who are mildly mentally retarded (ESN) do very markedly worse than normal adults. For example, when the correct response is to press the left-most window, the average success rate is about 25 as contrasted with 85 per cent. To say that the retarded have poorer memory than normal is true - but less informative than to notice that they deal differently with the task. A normal adult's performance reveals, on close analysis, an eight-step sequence of working. He exposes the first three letters in rapid succession; pauses and rehearses that first triplet of letters; exposes the last three letters in rapid succession; then without pause, exposes the probe letter; he then seeks the former location of the probe letter by searching through the most recently-seen three letters, which are still echoing in mind; if he finds the location there, he at once presses the corresponding window; if he does not find it, he now thinks back to the first, rehearsed triplet; if he finds the location there, he presses the corresponding window.

The normal adult, then, carries through this task by engaging in an intricate succession of activities which are, when we consider them, very finely adapted to the task. But the retarded adult approaches the task very differently. He moves through the task at a relatively uniform rate and searches for the location of the probe letter in a relatively haphazard way. As compared with the normal adult, his performance is indiscriminate and unadapted to the requirements of the task. But why? Further studies show that he is capable of carrying through all the necessary component activities. Indeed, if he is taught how and when to apply these activities, he performs as well as a normal adult.

In one teaching study, there were eight mildly retarded people aged 13 to 21 years. The first session was a pre-test on the memory task. On this pre-test, the success level can be summarized by saying that, when the correct window was one of the first three, Ss were correct on 28 per cent. of trials; when the correct window was one of the last three, Ss were correct on 53 per cent. of trials. A week later, there was a second session devoted to teaching these Ss the eight-step procedure which normal adults use spontaneously. At the end of this session, a post-test revealed that success rates were now 72 and 81 per cent. - a very large improvement. A week later, there was a third session which started with a retest on which success rates were 51 and 75 per cent. - a drop from the week before, but still better than the state of affairs at the beginning. The third session continued with further teaching and was rounded off by a final test in which success rates were 80 and 87 per cent. In these final tests, the retarded Ss were actually doing slightly better than normal adolescents.

In summary, on this memory task, retarded Ss do as well as normals after they have been taught in detail how to proceed with the task. (Interestingly, if any of the eight steps is omitted from training, success rate is poorer). So, the retarded command all the necessary component activities necessary for success. But they fail spontaneously to deploy these activities. Their weakness lies in diagnosing the task's requirements and selecting activities which are appropriate to these requirements. This weakness is further highlighted when the memory task

is altered in some way, e.g., if nine letters are exposed rather than six, or if an enforced delay is introduced before the probe letter can be seen. In the face of such alterations, normal people adjust their performance fairly quickly, and almost unawares. But retarded people do not show this adaptive flexibility. They tend to continue doing what they have been taught to do. They do not, as it were, reassess the situation.

These studies illustrate what is meant by saying that the capacity view of 'memory' is a half-truth. (This general point is elaborated in my book Memory, published by Penguin, 1964). In general, the retarded Ss do indeed do less well than the normal Ss, and it would be foolish to claim otherwise. On the other hand, the retarded Ss are clearly capable of being helped to do better. This is a fact which we are likely to overlook if we take a simple capacity view. The challenge, then, is to analyse the person's problem-solving performances in detail and work out what changes are needed in order to make these performances better adapted to the tasks in hand. The challenge is not, by any means, an easy one. But it is real.

The view that 'memory' is a fixed capacity is, as we have seen, a half-truth. The same holds for 'intelligence'. There is nothing wrong with defining a person's general intelligence with reference to his scores on some test of the IQ-type. For certain purposes, such a definition has great diagnostic and prognostic value. But the definition does not deal with all aspects of intelligence and, in particular says little about intelligence as a repertoire of problem-solving skills which are more or less appropriate to the person's way of life. Consider, again the Australian aborigines. Their way of life is well adapted to the harsh environment in which they live. They use many skills which we would have no hesitation in calling 'intelligent'. However, by the standards of IQ tests, they would be regarded as extremely 'unintelligent'. But consider that Europeans with high I Q have often been known to perish when they journey into the wastelands of the Australian desert. They are not 'intelligent' enough to find food, water and shelter.

So, who is the more 'intelligent', the illiterate aborigine or the European with his high IQ? The question is, of course, a trick question. It has to do, not with matters of fact, but with the way we define 'intelligence'. In comparing the aborigine and the white man, it is clearly inappropriate to use a fixed capacity, IQ definition of intelligence. For the purposes of this comparison, it is more useful to consider intelligence as a repertoire of problem-solving skills which is differentially appropriate to different environments.

DISCUSSION

Professor Hunter : Do you think that this can be applied to mental handicap in any way ?

Floor: The difficulty with something like that with the mentally handicapped is, I feel, to instil into their minds the equation between the marks and the message that you have given to them verbally. I feel that it would be hard work to try and use something like that.

Prof. Hunter: I wonder if it would be so difficult. Obviously if you were going to give a very complex message then the possibility of confusion would clearly arise but I would guess that the actual accompanying of the message by a gesture puts it in a concrete setting which enables them to remember it. Rather like putting a string of words into a rhyme or a song and giving it a rhythm tends to make it easier to remember.

Floor: Isn't this the sort of problem that arises when you're asking someone for directions? This is where I feel the message stick would be useful. For example, when you say 'third on the left' or whatever it is, because you can't actually see the words that are being said and you can't see the turnings?

Prof. Hunter: Well, quite interestingly in the last week when I was in a university library which I didn't know, I was being given instructions by one of the librarians as to how to find a section. What she did was to take a piece of paper and said "You go up to the fourth floor" and she didn't write "fourth", she just put a stroke on it, "and then when you go out turn right, and then you go down three shelves" and she made another stroke. Now it was almost like a message stick, it wasn't a depiction, it wasn't a map, it was just a putting down of some kind of reminder of what the successive steps were.

Floor: One of the first problems you would run into with the severely mentally handicapped is that if you say "Look. Stick" they just won't look. They haven't got this looking behaviour, or what is there is just very, very limited. There is no eye contact. That is one of the biggest problems we come up against.

Prof. Hunter: You mean that you are gyrating away in front of them and they are just not paying attention?

Floor: No, not so much not paying attention to what I'm doing but paying no attention very often to what they themselves are doing. He isn't even looking at what he's doing or if you perform the task and you want him to mimic it he doesn't watch you. It's this getting the attention on what he himself is doing that is the problem.

Prof. Hunter: Well, of course, if the person didn't have the general inclination to look at what was important, to select out from all that was going on that particular part, then this is a component which one would either say the person does not have and so this kind of task isn't on, or one would do something to try to make this component possible, to actually get the attention and the association, possibly with some fairly simple task to start off with. It opens the possibility of working down into the component parts.

I take your point about the severely mentally handicapped not paying

attention but you get it even with normal pre-school children. If you have had any experience of asking a small child to deliver a message for you: "Go next door and ask Mrs. Bloggs to come in for a cup of tea" - you say to the child: "I want you to go next door to Mrs. Bloggs ...." and he's out of the door! He's on his way to Mrs. Bloggs before he has even heard the rest of the message. So what you've got to do is programme the thing for him; you get hold of him and say "Now look, I want you to give a message to Mrs. Bloggs. Now the first thing you do is go out - don't stop to speak to the cat - and then you knock on the door, and when Mrs. Bloggs comes to the door what do you say?" And, what is striking is that normal children, certainly, have to go through a long, long process of learning to do this programming for themselves, but left to their own devices it is not an automatic routine thing.

Now, I know that relative to a lot of people that you are working with, these sorts of problems are minor. But they have this same quality that you have got to break the task down and actually get the person programmed to deal with the task in the appropriate way.

Floor: What relationship is there between memory and intelligence?

Prof. Hunter: Yes, that's one of these terribly flooring kinds of question because it all depends on what one means by memory and it depends even more on what one means by intelligence. Broadly speaking, there are two sorts of conception of intelligence - one is what you might call psychometric, the IQ type of conception, and the other one is the organic, clinical, Piagetian kind of conception where intelligence simply means the person's ability to deal with information, and in that second sense, memory is the same thing as intelligence. Indeed, any reflections which you can get of intelligence would also be seen in memory performance, ability to recall and so on. In other words, there would be these people who were very bright in the ordinary colloquial sense who would tend also to be very good in doing memory tasks. If you go back to the psychometric conception, then quite frankly the answer can be that there is a relationship between what you might call memory tests of a psychometric nature, and a global IQ score or very often there might not be. It is noticeable in the example of the Terman-Merrill tests, or the Binet test, a lot of the items are in fact straight memory items, asking people to remember words or digits or sentences or pictures, or something like this. So usually in that kind of psychometric situation there is a fairly high relationship, but not a perfect one, between total scores on the IQ and the sub-tests which are memory ones. But I must say that my own bias is to think of intelligence in a much more eclectic way, that is in terms of general information-processing capacity which may reflect itself in many ways.

For example, take the Australian Aborigines. In a straight psychometric sense they are not at all intelligent. They are not literate, especially the ones still living in the desert, but that doesn't mean in the other more common-sensical sense that they are not intelligent. They are adapted to an environment that would kill off you and me in a couple of days, and in fact if you say 'What sorts of things would Aborigines have to do in order to survive in an environment like this?' and you consider geographical orientation, for example, then they've got to be very good at that. They've got to be very good at identifying faint sounds, they've got to be very good at the visual recall of the layout of the terrain. Now if you base tasks on these and you give them to the Aborigine, even quite young children, they are streets ahead of rural, even semi-Aboriginal children who are living in the same sort of environment but

have an exceptionally literate, urban kind of orientation. So when I say streets ahead, I really do mean that. I've been looking at papers where real aboriginal children have been given tests, for example the Kims Game kind, where you present objects and get the child to look at them, then cover them over, then get the child to show in some way or another what the objects were. The Aboriginal children can obtain perfect scores on a distribution of something like twenty objects, whereas your rural European origin children will be doing something like ten. So there's a huge difference. So in that context, who's the brighter?

Floor: The reason for the question is that I think as we all know, the occasional subnormal has a fantastic memory for certain things. So I just wonder in that sort of case how much memory is related to intelligence.

Prof. Hunter: Well actually I'm very intrigued by feats of this kind for wherever you get an unusual talent, particularly alongside a lack, then this is vastly intriguing. I myself have not actually worked with any of these sorts of people who are sometimes called 'idiots savants'. One does often wonder how far this is due to some very unusual kind of gift the person has, how far is it an autistic kind of thing that the person has put all his energies into and is thus unable to cope with anything else. In some of the older textbooks a famous case was 'The Genius of Earlwood Asylum' and it always struck me that he really had a pretty good life. He was able to do his designs with no other responsibilities, and I am not sure how he would be classified today - probably autistic or something like this. Clearly he was exhibiting very high talents in his designs and projects but also he was totally institutionalised and unable to look after himself, and to that extent he wasn't generally able in any normal way. I think there are lots of very nice questions one could ask in relation to these 'idiots savants'.

Floor: Is there any evidence in the work that has been done on this that some Aborigines can carry these messages better than others? In other words, would the elders select particular youngsters for the job?

Prof. Hunter: There's no evidence that I know of about selection but obviously if a person were physically handicapped he would not be a messenger, and presumably if he were mentally handicapped he wouldn't make a terribly good one, so in that straight sense selection would be done. But it would be a pretty easy problem because you have only probably half a dozen people to choose from anyway. Does that answer the question?

Floor: Yes, that answers the question but what I was really getting at was, it would demand a certain level of ability before the individual could develop the concept required to remember what the notch represented on the stick, and this is a problem in fact with the mentally handicapped, that very, very simple concepts they can perhaps remember, but if it is in any way complex then that sort of system for carrying messages wouldn't work because they couldn't understand it. It might be better to work towards some simple symbols which they could learn.

Floor: You said that the Aborigines were illiterate. Do you know of any other illiterate peoples who use a system like that? I know the Ancient Greeks used to use a system of putting things mentally in a room in a house - mnemonics - and that since the advent of books etc. being available, are we losing our capacity to use these systems?

Prof. Hunter: Actually this is a very intriguing question. I have been intrigued myself to speculate on it. You see in the 18th century it was very commonly said - in fact all philosophers who commented said it, that as literacy spread so people became less able to remember things. My hunch is that on balance literacy increases the amount that you need to have in your head, because for one thing you can't just rely on language - and that is a big learning task. You have to learn the written word and all these symbols and how to write them and so on, and if you're working in almost any job you've got files, records... All this accumulation of data and the organization of it, the amount of data that the average person nowadays handles is very very much greater than the kind of data that you are likely to handle in a non-literate culture. I think the answer might well be that it's the literate people who have more demands but what they don't normally remember are for example, long poems, long songs, things of this kind which are very common in non-literate societies.

Floor: I can see the message sticks are really a form of enforced rehearsal - I read many years ago that the mentally handicapped don't actually spontaneously rehearse and I thought it was quite interesting that normal children take a very long time to get into this habit of rehearsing anything. I just wondered if there is any research evidence in normal children of differences in child-rearing practices with respect to memory, that some mothers encourage their children to develop this strategy for memory and others don't?

Prof. Hunter: There's no hard evidence that I know of. However, as one moves about and becomes familiar with parents and children, one certainly notices that in some families there is quite a lot of talk about ways of remembering things, and the phrase "an easy way to remember this", or "how would you remember this?" occurs quite a lot. Whereas in other family contexts one gets the impression that this sort of thing is never coaxed at all and I would guess that you could pick out families where the children would be much more sophisticated than other children in matters of what they need to memorise. You can do quite simple problems like saying to a child "Suppose somebody asks you to go skating tomorrow and you've got to go straight after school, what sort of things could you do to make sure that you don't forget your skates in the morning?" Now, when you get problems of this kind there are quite big differences among normal children in the extent to which they can think of anything to do, even "Tell Mummy to tell me", but nobody has yet looked at this in terms of family background. I think one could, and I would guess that parental bias would show up very much indeed.

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OPENING THE DOOR - IMPRESSIONS OF HOSPITAL CARE

John Brown

Lecturer in Social Administration, University of York.

Introduction

Three years ago 'Opening the Door' reported the research of a team, of which I was a member, that had investigated the quality of care in all the twenty-six hospitals for the mentally handicapped in a former regional hospital board area (1). The title of the book was chosen deliberately to be set against Pauline Morris's earlier national study 'Put Away' (2) to indicate what was felt to be in many respects a different approach to the understanding of the difficulties faced by all those who care for the mentally handicapped in hospital.

Since publication change in the quality of care in the hospitals studied has not appreciably improved - not that there has been no change. The number of occupied beds in some of the hospitals has decreased and attempts to introduce 'progressive' policies have been made. But much as such change is to be welcomed the result of these developments for many nurses has been the feeling that there is an increasing proportion of 'difficult' patients in hospital to care for which 'progressive' policies, usually involving a small number of patients who are already benefiting from other services and facilities in the hospital, do not touch. The difficulties faced by the nurse are just as acute, and some would say more acute, than when the research was conducted. It is the difficulties and experiences of the nurse on the ward that provide the focus for my observations and reflections on 'Opening the Door'. These observations and reflections are based not only on my experience but also that of my two colleagues, Professor Kathleen Jones and Peter Williams. (3)

In my comments I will not be directly concerned with the types of questions that are, and have been, involved in the continuing debate over the Briggs Committee recommendations nor with the possible deliberations of the Jay Committee - questions about professional status, career opportunities and possible future developments. Whether nurses of the mentally handicapped remain 'nurses' or become members of a caring profession which provides hospital-based family support it is clear that for the foreseeable future they will provide the mainstay of care for the mentally handicapped. Maureen Oswin, for example, has illustrated recently in 'Children Living in Long Stay Hospitals' that other professional groups, such as psychologists, speech therapists, and the like, are not attracted to work with the mentally handicapped.(4) Nor do I wish to consider debates over the allocation of priorities and resources, such as those associated with the priorities document 'The Way Forward' (5), or whether care should be in the community or in the hospital. As the National Development Team's report on the health Service hostels attached to Tatchbury Hospital indicates the difficulties are more involved and intractable than many commentators would acknowledge. (6)

The question that I want to consider can be stated simply but is notoriously difficult to answer - how does the nurse acquire his/her attitudes and specific forms of behaviour towards the mentally handicapped? In short, how does the nurse learn about mental handicap?

The Authoritarian Nurse?

The assumption I will make is that where authoritarian behaviour occurs this is not necessarily due to an authoritarian personality but reflects the experience of working on the ward. Over the past decade, there has been a tremendous volume of literature on how the mentally handicapped child or adult learns that has not been matched on how the nurse learns about mental handicap. Not that there has been a lack of comment about nursing care: indeed a belief has emerged among some social scientists that nurses are, automatically through the fact of being a nurse, authoritarian and therefore create a rigid structure in which a custodial regime is inevitable and the mentally handicapped suffer. In many hospitals and on many wards this is undeniably, and tragically, the case and such a rationale could explain the behaviour I encountered while working for a short spell as a nursing assistant prior to the research. This was in a hospital outside the region on which 'Opening the Door' is based.

Three beliefs and associated examples illustrate the type of incidents that lead to the criticism of nurses:

1. Patients are insensitive. Mr. Pelham, a severely subnormal patient who is paralysed from the waist down, had been put to bed at 7 p.m. and at 8.30 p.m. had been checked just before the change of shift. He had been doubly incontinent and was bathed and the bed changed. When put back into bed, he was taunted and teased by Mr. Nelson, a nursing assistant. Mr. Newby, a pupil nurse, balancing on the end of the bed, then flung himself across Mr. Pelham's legs. Mr. Pelham then wet himself. The suggestion that this was a good example of how incontinence could have an emotional basis was dismissed by an emphatic 'No - he's just a dirty --' from Mr. Newby.

2. Patients cannot meaningfully discriminate. The ward had recently been redecorated and upgraded, presenting a very agreeable physical environment which had every facility to cope with a difficult and often nauseating job: it made the nurses' job much easier in dealing with doubly incontinent patients. While this was acknowledged by the staff, it was still resented that difficult patients should be in a ward with such an agreeable environment: 'They can't appreciate it. It's wasted on them. It's much better to put some of the old-timers in these "new" wards. They've worked hard some of them, and they know what it means to be in a ward like this.'

3. Patients cannot be taught. Mr. Potter had been doubly incontinent. Now he was one of only five in the ward who were not. When asked why, Mr. Newby replied, 'It just happened. No one really knows why'. To say that incidents and beliefs such as these reflect an authoritarian attitude tells us little about how such attitudes are developed and allowed to express themselves.

It may be that nurses in mental handicap are authoritarian personalities; it may be that they are not as 'bright' as their colleagues in other nursing disciplines in terms of educational background and success in GNC examinations. Such reasons, however, should not divert us from analysing, and trying to understand, the clinical situation in which the nurse works - for it is on the ward that good and bad attitudes are learnt. What I will, therefore, attempt to do is forward one possible explanation of how the nurse learns about mental handicap and discuss the implications of the analysis for training. The way I will approach this is to begin by considering how the new nurse learns about the structure of care on the ward.

The Structure of Care

In the report of the Committee of Inquiry under the chairmanship of Geoffrey Howe into conditions at Ely Hospital a comment is made that "familiarity dulls perception". (7) Such a statement is particularly appropriate when considering the impact of seeing a ward of mentally handicapped patients for the first time. Those who are concerned with caring for the mentally handicapped can be extremely blasé about conditions which to the newcomer are a source of bewilderment consisting often of distressing sights, sounds and smells. Irrespective of the reason why that person has become a 'nurse', and the reasons are many, such distress is often tempered with compassion: if you are friendly and show a little affection then you will be able to cope with these patients.

But, as you are well aware, friendly affection is of limited use as the newcomer soon learns. For example, a patient might respond by being friendly himself and placing an arm around the newcomer's shoulder but scream inconsolably when the arm is removed only quietening down when the arm is replaced. Or the shoulder might be gripped firmly making it difficult for the newcomer to extricate himself. Friendly affection might be a way of responding to a distressing experience but it is of limited value in telling the nurse what to do in a large number of situations and is of little use in explaining behaviour and allowing the nurse to understand what is happening. To get such explanation the nurse, like any other newcomer in a job, turns to his immediate colleagues for advice and assistance. Again like any other newcomer the nurse quickly learns there are some people you listen to and some people you ignore.

Those whose explanations you ignore (although you may not be able to ignore their authority) could include voluntary workers, medical consultants, nurse tutors, even the sister or charge nurse on the next shift. In fact, it could be anyone who is seen as not offering help with the job at hand. One charge nurse referred to such people as 'theorists' - a term whose derogatory implications are clear.

It is important to note that those who are not regarded as 'theorists', those whose experience is drawn upon because they possess credibility, are not necessarily charge nurses or sisters. If they are listened to by nursing assistants, pupil nurses or student nurses then it is not because of the fact of their being trained.

85% of a sample of 196 nurses in 'Opening the Door' agreed with the statement that "When looking after patients, ability and common-sense are more important than formal training". Among those who were untrained (136), 93% agreed with the statement while 65% of those who had been trained (60) also agreed with it. (8) Such figures do not necessarily mean that ward staff think formal training is not important, only that they attach greater importance to ability and common-sense.

This is graphically illustrated by the observation that to have been trained can be an embarrassment and present the charge nurse or sister with an acute management problem. The problem was to either stay in the office or go out on the ward. If he stayed in the office stressing the administrative nature of his work he might have the following accusation, actually made by an SEN, forwarded:

> I don't begrudge him the money he earns, anyone who does this work deserves every penny they get. What makes it unfair is that he does less work than any of us .... he stays in his office and drinks tea all day and never comes out and lends us a hand, even when we are down to just two of us and all the feeding to do. He says he's got a lot of paper work to do, but I've been in there when he's not been around and the paper work turns out to be his football pools or a novel .... I'm not complaining about the money I take home, but I don't think it's right that he gets that much more and doesn't have to do anything for it.

However, if the charge nurse did come out on to the ward and 'lend a hand', he risked devaluing his status: he has few specific techniques to offer, and his performance of the basic tasks of toileting, washing, dressing and feeding was unlikely to be superior to that of an untrained nurse with a few weeks' experience. There may occasionally be satisfying professional tasks to perform, like taking a patient's blood pressure, suturing a wound or treating a laceration, but such opportunities of demonstrating expertise are comparatively rare.

To escape from this double bind requires remarkable qualities of personality and administrative understanding; but people with these qualities are more likely to be promoted to the nursing hierarchy rather than to be found on the ward for any period of time. The charge nurse or sister is not a person that you necessarily turn to, therefore, because they have been trained - the relevance of training which this raises is something I wish to return to later. The person who you do turn to is someone who can provide an explanation for the distressing sights, sounds and smells referred to earlier and more importantly, the behaviour which often appears to defy 'common-sense'. Such behaviour can cover a wide variety of situations.

Patients often do not show a proper regard for others with whom they come into contact, or may fail to signify consciousness of the presence of others. They may fail to be aware of their own existence. For example, they may mutilate and defile themselves. Often they fail to meet the requirements of the social setting they are in. For example, they may masturbate openly in a public place, or, more generally, do the right thing but in the wrong place. Patients may also persist in a line of action beyond the point at which it is suitable. They may continue playing when meal times arrive, or they may start a conversation with

someone but continue to loop back to the initial greeting, or they may stay on the toilet for several hours because no-one has told them they can get up.

Many other examples could be quoted, all of them difficult to explain and perplexing to the new nurse. However, from those he comes in contact with on the ward the nurse learns three 'facts' which accounted for such situations:

1. Subnormality of intelligence is a total disability which affects all aspects of a person's being and which is likely to be correlated with other types of disability. Mentally handicapped people are likely, therefore, to be deaf, to have behaviour problems, and to have other organic impairments.

2. Such disabilities are irreversible because they stem from known types of organic impairments and are untreatable. The causes of mental handicap are therefore to be found in such things as brain damage, chromosomal abnormalities and prenatal injuries. 62% of the 196 nurses in the attitude survey for 'Opening the Door' agreed with the statement "There is a sharp dividing line between "normal" and "mentally subnormal" (9) They would obviously agree with R.F. Tredgold who in the first edition of his textbook 'Mental Retardation' (1908) stated emphatically that 'between the lowest normal and highest ament, a great and impassable gulf is fixed" rather than agreeing with the 1971 White Paper 'Better Services for the Mentally Handicapped' which sees mental handicap as lying on a continuum of ability. (10)

3. As a result of points 1. and 2. such people are incapable of development and odd behaviour that defies common-sense can be explained and understood. As one charge nurse stated 'they haven't got a brain'. A further implication is that such people will have to be looked after by others for the whole of their lives and it is, therefore, unrealistic to assume that they can ever be discharged from the hospital.

Such an explanation, popularly referred to as 'the medical model', is what the majority of nurses at the time of the survey learnt and believed about mental handicap. The explanation is learnt, not necessarily in times set aside for formal learning, but usually in discussion with staff as a response to specific events. When, for example, a new nurse is confronted by a patient who, after coming back from the toilet, urinates in his trousers, this is likely to be the occasion for a discussion with other staff concerning the reasons for this. These discussions tend to be informal and of limited duration, and generally take place on the ward rather than in the canteen or other hospital settings. It is through these informal discussions that attitudes towards the mentally handicapped are created and developed.

The advantage of the medical model is that it provides an explanation of behaviour in the ward setting which, by stressing the innate helplessness of patients, provides a rationale for the dominance of routine in ward management - a dominance which has profound importance in the structure of care experienced by the mentally handicapped. Routine has been extensively criticised but many justifications for its use were forwarded: Routine is necessary because the patients need 'everything done for them'. They have to be toileted, washed, dressed and fed, and with staff shortages, this takes up the whole day.

Routine is necessary because they are 'like children' and parents must not have favourites.

Routine is necessary because patients have to 'do as they are told', and behave like good children.

Routine is necessary because there would be 'no end of trouble if they did as they liked'. They might injure themselves, and the nursing staff would get the blame.

Routine is necessary because 'the other staff will duck out of their share if they get the chance'.

Routine is necessary because 'we don't work as a team - why should we?'

Routine makes for a smooth-running ward, minimises disturbed behaviour, provides automatic checks that necessary procedures have been carried out for all patients, and prevents or lessens the effect of incidents; and above all, routine makes it possible to satisfy one's superiors.

In these justifications for routine five aspects of the structure of care that we observed on the wards can be identified:

1. emphasis on adopting a parental role
2. emphasis on patient compliance
3. a constriction of patient learning opportunities
4. minimal task performance by staff
5. low staff solidarity.

1. Adopting a parental role.

Family-linked metaphors are often evoked. Terms like 'creating a home-like environment', 'a warm and happy atmosphere', 'trying to make the ward into a proper home for them', all reinforce an image of the ward as a setting in which family-like relationships flourish: 'We are like father figures to them or parents, and no more like nurses than that. No, this isn't a hospital it's a community, and this ward is their home'.

The family model is the one most readily to hand, since it is the one of which most staff have personal experience. It has considerable legitimacy, giving them a mode of helping dependent people and a set of criteria by which they can be evaluated; but there are other consequences which are less desirable.

Nurses felt that patients should be treated like their own children, and subjected to the same rules that they apply to their own families. This means that the use of punishment is seen as reasonable and just. Charge nurses commented on a number of occasions that if their own children at home misbehaved, they would not hesitate to slap them, since this was a just and immediate punishment readily understood.

> The doctors say we should treat them as our own kids, so that's what we do. If my son does something wrong I tell him to stop it, and I warn him that if he does it again he'll be for the high jump. If he carried on with it I warn him again and if that doesn't work I give him a slap and that soon enough stops him. It's the same with the patients.

Very often, too, nurses invoke the family rule of 'no favouritism', which means that all patients should be treated the same, and none should get special attention. To single a patient out is generally frowned upon as 'spoiling'. Yet it may be precisely the quality of special and individualised treatment which is necessary if a patient is to show improvement. Therapy and the family model pull in opposite directions.

2. Emphasis on patient compliance

The authority that nurses, particularly charge nurses, claim over their patients is legitimised by their assumption of the parent's role rather than by any special knowledge or expertise they have acquired in training. The converse side of this equation is that patients are expected to do as they are told. Like children who do not appreciate the meaning of their own actions, patients are fostered in a compliant role which is superimposed on their already limited potential. For example, nurses may reinforce their own position by giving patients approval for engaging in actions that demonstrate their lack of understanding and self-respect:

Nurse: What are you, Pinky?

Patient: I'm a silly twit-twat.

Nurse: That's right, and why are you a silly twit-twat?

Patient: Because I haven't got a brain.

3. Constriction of learning opportunities

From compliance springs a very negative pattern of ward culture. Patients learn (and they do learn) that they are valued for their ability to do what they are told to do when they are told to do it; and this constricts any other opportunities for learning, because new or innovative behaviour is likely to be seen as non-compliance. Further, while many staff hold to the 'family' model of ward organisation, they tend to see this exclusively in terms of parent-child relationships, and not in terms of sibling relationships. Patients are encouraged to relate to them, but not to each other; indeed, certain types of play and exploratory behaviour which would be expected in real families may be frowned on as interfering with the performance of routine, or leading to a state of over-excitement.

Patients' learning opportunities are further constricted by the limitations of the 'normal' adults they are able to observe. Ward visitors are few, and the behaviour of the nurses is therefore their chief source of information; but on 'back wards', staff behaviour to patients is

often of an exaggerated and authoritarian kind. Commands are not spoken, they are shouted. Gestures are not simply made, they are acted out so that their meaning is unmistakable. Since most interactions tend to have this aggressive character, it would follow that if patients learn from staff they will learn to be submissive in interaction with them and dominating in their contacts with one another.

Phrases like 'Sit down!', 'Shut up!', 'Close the door!','I'll thump you one, if you don't...', closely mirror those used by nurses, while gestures such as walking up to another patient and standing very close to him and at the same time leaning forward are equally frequent among those patients who lack verbal skills.

4. Minimal task performance by staff

Because patients' learning opportunities are constricted, and only predictable behaviour is required, the ward becomes a very dull place, without a spontaneous life of its own. Staff have no motivation to complete their tasks at anything more than the minimum level necessary to retain the approval of the sister or charge nurse; and the range of tasks which they are called upon to perform is neither varied nor skilled. Apart from specifically clinical treatments, the work, though often arduous, is not complex. Bathing, feeding, dressing, toileting are tasks well within the capacity of most adults, and they require little training.

Work patterns for staff tend to be highly predictable. Days when special tasks have to be performed, for example sending clothing to the sewing room for repairs or 'condemns', are usually specified by hospital policy. There is little opportunity for initiative.

5. Low staff solidarity

Low standards and low levels of solidarity go hand in hand. They are manifested in such reactions as the willingness of a nurse to leave a task for someone else to do, even though he has the time to do it himself. For example, a nurse, on noticing that a patient had soiled himself, commented to another member of ward staff: 'Norman can do that when he gets back from breakfast. I've already changed him once this morning.' Neither of the two nurses was doing anything except general supervision at the time.

These points are a synopsis of, and taken from, part of the analysis to be found in 'Opening the Door' (11). They are one attempt to understand the way nurses relate to mentally handicapped patients and to appreciate the difficulties faced by them in coping with a situation many of the critics could not stand for any period of time. Given the structure of care identified what are the implications for training?

Implications for Training

The overall scepticism felt by the majority of nursing staff towards training has already been mentioned. The medical model provides both an explanation of behaviour and, with its support of routine, a method of coping with the demands of the ward. Training appeared to offer no

comparable techniques that were as effective in coping with the reality of ward-life. This resulted in two attitudes towards training - shelving and displacement.

Shelving referred to the common situation where a nurse would comment that training "was all very well and good and there are some interesting ideas. But of course it's different on my ward." Such an attitude can also be found where PAC forms stay resolutely in the charge nurse's desk.

Displacement referred to a situation where a means to an end became an end in itself. For example, Cliff Cunningham, a project director at the Hester Adrian Research Centre has stated with reference to the education of mentally handicapped children:

> "Behaviour modification is an extremely good technique. You can control and train a person not to be a nuisance and how to function well in the institution, but this could well be denying them the ability of integrating as a person into society. You could find the child doesn't dress and teach him to dress very effectively. All you've got is a dressing robot. To me the whole function of education is to give people the tools to make choice in a rational way. If the teaching programme dictates to the child exactly what to do and programmes for 100 per cent. success what we have removed from the child is the opportunity to make decisions to think for himself and cope with uncertainty." (12)

If shelving and displacement are to be combated and the situation on the ward influenced by training then it is necessary to be clear about, firstly, the purpose of training and, secondly, the expectations associated with working on the ward.

The Purpose of Training

Nearly twenty years ago a nurse attached to the Tavistock Institute in London, Isobel Menzies, published a paper in which she tried to account for the reason why nurses in acute medicine treated patients as depersonalised objects (13). Mrs. Smith, for example, was referred to as 'the appendectomy in bed 14' and nursing staff would distance themselves from getting personally involved. The reason that was forwarded to account for this was that such practices were seen as 'a defence against anxiety'. In the nature of acute medicine, not all patients get well, many die while still in hospital and to become personally involved with patients could prove to be emotionally stressful affecting their performance as nurses. To deny the personality of the person ill in hospital minimised this possibility and shields the nurse against emotional involvement.

This analysis is useful for clarifying the purpose of training in mental handicap, not for what it says but for what it assumes. The nurse can only experience anxiety if a personal relationship has been established. It is this assumption that is problematic in mental handicap - items associated with the 'defence against anxiety', depersonalization and the like are erected not because of emotions associated with a personal relationship but because such relationships can be notoriously difficult to establish. One commentator has used the term 'alienation' to refer to this type of

situation where, because staff cannot 'heal' or 'cure' they withdraw into an impersonality which protects them from what is seen as failure. (14) Interestingly the 1971 White Paper "Better Services for the Mentally Handicapped" specifies objectives that assume it is possible to establish personal relationships (15). I would argue, however, that such objectives will not be attained unless training programmes recognise that establishing personal relationships is the preliminary aim before specific objectives are sought. Associated with this would be the realistic appreciation of what can be obtained in a given period of time with a particular patient. Expectations of nursing staff have to recognise the considerable time and effort necessary to evoke what would in normal circumstances be regarded as a modest response. A young male nursing assistant, for example, recounted how he had tried to establish contact with a particular patient for several weeks without success. When he had given up hope, the patient walked up to him and gave him a cigarette butt - 'and I nearly burst into tears'.

The purpose of training would be, therefore, to help establish personal relationships with patients associated with meaningful expectations of patient response.

Work Expectations on the Ward

In analysing behaviour on the ward focus has been placed on how nurses learn to cope and the implications this has for certain practices. Nurses, however, are not only expected to cope with the basic tasks of washing, feeding and changing they are also according to objective number five of the 1971 White Paper expected to provide, in conjunction with other workers:

> ... stimulation, social training and education and purposeful occupation or employment in order to develop to (the handicapped person's) maximum capacity and to exercise all the skills he acquires, however limited they may be." (16)

In the work of the nurse and the structure of care on the ward it is therefore possible to distinguish between strategies for coping, associated with washing, feeding and changing and strategies for enabling, associated with developing the patients' skills and potential.

A related distinction is made by Michael Bayley when studying families who cared for their mentally handicapped children at home. He saw what he referred to as the structure of coping, meeting the needs of the child, as directly influencing the structure of living, the social life of the family (17). Similarly, in the hospital context strategies for coping can be seen as directly influencing strategies for enabling - unless appropriate strategies for coping are learnt then the introduction of various strategies for enabling will inevitably be compromised - 'displaced' to use the term introduced earlier. It is, therefore, crucial to direct training programmes initially to the needs associated with coping on the ward.

Only in this way will a solid foundation be established on which strategies for enabling will be introduced to develop the skills of both

patients and staff. For, like Michael Bayley, I believe that if we are to help the mentally handicapped we should help the helpers. This is something we seem to be increasingly willing to do when the child is at home when cared for by parents but loath to do when the child is in hospital when cared for by nurses. Strategies for enabling refers, therefore, to both patients and staff and I see the objectives of the 1971 White Paper in developing potential applying to both groups and not to patients exclusively.

The Structure of Coping

If the structure of coping is crucial it is imperative to isolate the skills needed to provide care in this area and which enable the new nurse to 'make sense' of odd and often bizarre behaviour. As already mentioned the purpose of these skills would be to not only understand such behaviour but facilitate the creation of personal relationships. Three skills appear particularly crucial.

Firstly, skills of communication. What is needed is the development of verbal and non-verbal ability in communicating with the mentally handicapped. Non-verbal means of communicating are especially important - in the sample of 1,541 patients in 'Opening the Door' just over 40% had no speech or odd words only (18). Recent publications from the Hester Adrian Research Centre such as 'Let me Speak' (19), while intended for parents, are very useful sources for nurses as well in evaluating patient competence and developing and fostering verbal skills among the mentally handicapped.

Secondly, skills in group management. There is an ever increasing body of expertise evolving in group work that could be adapted to helping staff cope with, for example, the demands faced first thing on the morning shift, colleagues have failed to turn up, patients are still in bed and everyone has to be got ready for breakfast.

Thirdly, skills in coping with aggression. Fear of violence is an underlying worry and there is now more informed comment than the advice that tended to be forwarded a few years ago that if in doubt ask the charge nurse. This was of little use to the nursing assistant who when drying a patient after a bath finds the patient drops to the ground and sinks his teeth into the calf muscle. When he tries to move the grip gets tighter - at times such as this asking for advice is too late. South East Thames Regional Health Authority have recently produced a film 'Guidelines to the nursing management of violence' and a booklet 'Nursing management of violent patients' which provide clear and useful practical suggestions for ways of dealing with violent incidents. (20).

These three skills are not the only ones required but they are an attempt to provide the nurse with the initial confidence to cope with demanding situations which will provide a sufficient basis to develop strategies for enabling. There are, obviously, many other factors involved, one of which is the role of The General Nursing Council.

Throughout the survey the General Nursing Council held a unique position - as both a scapegoat and an excuse. Bad practice persisted and innovation was resisted because, many nurses claimed, of the necessity

of meeting the demands of the G.N.C.'s syllabus. My talk has been at a general level and it is possible to point to exceptions to the situation outlined. Such exceptions have emerged in spite of the GNC syllabus indicating that, as with the law, interpretation is crucial. Further, recent developments from the GNC, namely the revised 'Syllabus for the Roll of Nurses for the Mentally Subnormal' published in February this year indicate that the GNC is well aware of the difficulties faced by the nurse - particularly with the revised content of Section Two 'Concepts of Mental Handicap - Care, Teaching (or Education) and Training of the Mentally Subnormal'. (21)

In spite of these developments there is still a long way to go. Throughout the Briggs Committee recommendations, for example, belief is expressed in basing training within the clinical context. (22) But in their chapter on the learning process and learning environment, focus is on the structure of training rather than on analysing the quality of training that the student or pupil experiences on the ward. Such an approach is typical. But unless an attempt is made to understand and isolate how such experiences influence attitudes and behaviour then we will continue to forward recommendations that will be palliatives rather than cures. And this will be a disservice to the nurses and the patients in their care.

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DISCUSSION

Floor: Did you find anything that was good? I just get the impression listening to all that that we tutors are wasting our time.

Mr. Brown: I think to some extent the nursing profession has let the nurses down. After having spent only a very short time as a nursing assistant I've a great deal of sympathy for nursing staff who tend to get very little support from anybody, including nurse tutors - they were just left on the ward to get on with the job. There were some wards which got all the help but the really bad, intractable problems tended just to be allowed to stagnate and this was what was worrying the nurses working on the wards. They got the feeling - I've got no evidence for this - they got the feeling that they were increasingly being left to care for the patients who were difficult, the really intractable cases while all the effort went on reducing hospital beds by getting those who could respond out into the community, and this was where the resources were.

There was a speech therapist but those on the back wards just never had such services. Now admittedly there are physical difficulties in stretching one speech therapist out among all the hospitals and all the patients, but its just that there was this overall feeling of despair that nobody was helping the nurses. There was all this talk about various techniques - there were these various programmes happening down in the South of England, for example, but they felt that they were just being

left high and dry. Yes, there were some good things being done, but there was an awful lot where people were just being forgotten about, where there was an awful lot of frustration as well as bitterness.

I think the emphasis we have on helping the mentally handicapped - which is excellent - might perhaps be better placed if we started looking at trying to help the nurses - make that the prime objective. I'm sure the spin-off of giving nurses the confidence in their own skills to cope would hopefully then help the mentally handicapped. It's idealism, if you like, but that was the one thing that was lacking on a lot of the wards.

Floor: I'd like to stick my neck out, Mr. Brown, and thank you very much for saying what a lot of nurses have felt for some time about conditions on some of the wards in particular. As a nurse educationalist, I get nurses constantly expressing these things and it gets very frustrating when you are dealing with frustrated learners who we know are having these attitudes put to them all the time. We try to get rid of them, and of course we can't be in two places at once. It's frustrating for them and it's frustrating for us, and the patients don't benefit from it. I do, however, think it's worth pointing out that these conditions do not only exist in subnormality hospitals but also in other hospitals - certainly in psychiatry and in some of the back wards of some general hospitals as well.

Floor: Firstly, I'm a charge nurse on a back ward. About 3 or 4 years ago I took over this ward where all the adult patients with a bad record of disruptive behaviour were put, and it was appalling. One of the things we were faced with in an attempt to put the situation right was to get the staff functioning as a team before we did anything else. I would certainly agree with your comment that you have to put emphasis on the situation of the staff, because my experience over the last 3 or 4 years has shown that if you treat the staff well then the patient care improves too. What we were faced with initially was what to do with the ward in the sense that we were going to train the patients. We had to decide whether to train a small group of patients and put them through some very intensive training programme or to spread what we'd got right across all 35 patients knowing that if we did that it wouldn't be so intense for each individual. What we did was to get the staff together and let them thrash it out between them and they opted to spread our resources thinly across all the patients in the ward. Now in the light of this experience I should say that was the right decision because it certainly paid off. We brought in a behavioural model and we started to teach operant conditioning to staff who had no concept of the behavioural model at all. We used behaviour modification to bring about change. I wouldn't necessarily agree with the comment that you end up as a conditioned robot - I wouldn't accept that at all. We've changed the ward quite considerably over these four years - in fact it's now no longer a back ward.

One of the things we did was to make changes in the actual management of the ward. When we first took it over the staff were task orientated - you bathed a patient, someone else shaved him, someone else dressed him and nobody really looked after an individual patient. We changed that completely to a patient-orientation approach by splitting the ward into four groups of 8 or 9 patients and allocating staff to work with a particular patient group. Thus two staff worked alternately so there was one on all the time and they were totally responsible for the total care. That brought about quite a lot of change. We encouraged the staff a lot so that they were made to feel they were doing the right thing, and even though it wasn't that good at first it is good now. So I think what we are up against is what the charge nurse thinks. It's ultimately up to the manager of that ward - if he wants a back ward then he's going to end up with a back ward if that's what he's prepared to accept.

Mr. Brown: Yes, I think one of the difficulties with back wards - a gross generalisation now - is that back wards tend to be not only a place to dump problem patients but also a place to dump problem staff. Obviously this didn't happen in your case.

The problem with behaviour modification, I think, is that you can tend to relate to patients as robots but I think too it's got tremendous potential. One of its greatest attributes is that if it doesn't work then you don't blame the patient, it's because the programme you've devised is wrong. I think that is where the strength of it lies but the point is that it can be used just to keep everyone quiet and docile and make the nurses life a lot easier.

Floor: I'm not trained in this particular specialty but it astonishes me that as a profession we can talk about behaviour modification in terms of patients and yet we've programmed a certain percentage of staff to behave in a certain way for years and approved it. They've gone on keeping the ward tidy and the patients relatively clean and so on, and now we can't expect them to change without educating them as well. We've talked about the frustration of the educationalists which is immense, I am sure, and the frustration of the learners is incredible, but the ones in the middle are the ones who are having it from both sides and those are the charge nurses who have not got the opportunity they see themselves plodding ahead for day after day.

Mr. Brown: Yes, I think in many respects that's true.

Floor: I think the charge nurse gets the opportunities he creates.

Floor: Yes, but you do have problems such as lack of support and I think this is a problem which all charge nurses come up against. You (previous speaker) have a particular skill in behaviour modification but I think most charge nurses lack a particular skill and I think that as Mr. Brown says, we need an expertise that we can offer to others. I think we should train the people that are going to do the work - the ones who are already in senior positions.

Floor: How do you study the attitudes of the managers?

Mr. Brown: Who, Nursing Officers upwards? (Yes). Well that is where you get the difficulty coming in.

Floor: You say you interviewed 196 nurses. Well, from the conclusions you've drawn up in your paper do you think this is a fair cross-section of opinion representing the thousands of nurses in the mental handicap field in this country?

Mr. Brown: The 196 nurses were from 26 hospitals which made up the complete set in one regional hospital board for mental handicap.

Floor: You've just seen the hospitals in one region then?

Mr. Brown: Yes, it's just one regional authority which has unique geographical factors, I'm sure. I would say that within various statistical limits and the way that the nursing staff were selected for interview that

they're as representative as we could make them for that particular area. I generalise to the country as a whole because I think that I've been to some hospitals where I've encountered similar attitudes. I wouldn't like to say that these attitudes are prevalent in the country as a whole, they might be, but I've no way of knowing that.

Floor: Because quite honestly, I don't think you've been fair to the country as a whole.

Mr. Brown: Well, as I say, I've painted a deliberately dark, black picture.

Floor: I think he's painted a totally black picture because I've visited many hospitals in the country and they're nowhere near as bad as that.

Mr. Brown: Yes, I've seen better but I've also seen worse as well.

Floor: People say we are supposed to look forward these days in mental handicap hospitals. Perhaps you could present your paper to members of the profession who have more hold of the purse strings.

Mr. Brown: The book on which my paper was based has been presented to various influential bodies but personally I don't feel that much has come out of it. One of the things which has happened during the course of the research has been the take-off of things such as behaviour modification. One thing that struck us when we went round was that there was a feeling that there had to be change. When we started, Ely had been published and nurses were generally getting the blame so there was a feeling that something was wrong. People acknowledged that things were wrong. The Government's reply was the White Paper "Better Services for the Mentally Handicapped" which has got laudable objectives, but the best objectives can be of no use when you go to work at 7.30 a.m., it's pouring with rain and nobody has turned up to help you.

Behaviour modification has helped but let us not forget that the medical model is excellent for the nurse working on the ward - it tells you what to do, it explains it and it justifies the routine. It enables you to get through your shift which very few techniques at that time did.

Floor: You've painted what seems to me a picture of a vicious circle whereby the training and attitude formation of the new nurse occurs on the ward and then her attitudes determine her work on the ward and so the vicious circle continues. How best can you see this vicious circle being broken?

Mr. Brown: If I knew that I would have been swallowed up by the DHSS a long time ago. Part of it is, I think, in creating confidence, but the other thing is to try and create some programme where nursing staff don't necessarily evaluate how a patient is getting on but they can evaluate how they themselves are getting on. People come into mental handicap nursing for a variety of reasons but I think that irrespective of whether we should have nurses or what have you, most people want to get the feeling that they're doing something and they're getting something out of their job. A lot of them have got the attitude that it's a Ford Halewood, 9-5 type of job which you do for the money. Well I don't think many people in mental handicap do it for the money but I think if you can show people that they are actually achieving something, this facilitates motivation.

Floor: You're back to the same problem again though, Mr. Brown, because if they're coping with the situation as it is and they're approved at the end of the day, then that's the way they'll go on unless there are the presumably fairly special ones who manage to break away from the routine. Then we're back to the vicious circle again and it seems to me we won't totally change it unless we help those that are actually in post, and stuck, hidden behind their badge.

Mr. Brown: Yes, I agree that is the level at which the change will come - where change can be focussed and be at its most constructive.

Floor: One of the things we did when we set about teaching patients self-help skills was to use a method of assessment that didn't assess what a patient did but did in fact assess how much help he needed in completing that task. So the staff actually dressing him had to jot down what they did and not what the patient did in the hope that we could eventually withdraw some of that help. The interesting thing was the reaction from management, though - the reaction of the nursing officer of the unit was 'That's all very well doing behaviour modification and teaching, but who's going to do the work?' That was his attitude. So that's what it's about as far as I'm concerned - you have to start at the top because you've got to change that attitude and pass it down the line - you can't start at the bottom.

Floor: We organised an in-service course for qualified staff from the bottom and it worked all the way up to the top and they approved it, and it was a great success. It's left a door open and I'm very pleased about that.

Mr. Brown: I think one of the difficulties is that there is so much uncertainty about where the profession is going. I said I wasn't going to look at Briggs or the Jay Committee but I should imagine it must be incredibly depressing over the years, since it came out in 1972, to have this debate and wrangle about the status of the profession, the career opportunities that are going to be produced, etc.

Floor: I think that in the mental handicap profession one of the problems we're up against is that we have very few specialists.

Floor: But there are training courses now which are improving the situation.

Floor: Yes, but very few people take up these opportunities and even fewer Area Health Authorities allow them to do so.

Floor: If something new is introduced, like the Pupil Nurse Syllabus, the people who ought to be trained first in the new syllabus should be the charge nurse, but it isn't so. Pupil nurses are trained in the school, we apply the new programme, we train them and then they go on the wards and the people on the wards don't know what it's all about.

Floor: One of the problems on the wards, in my experience, is that there's very little connection between the training school and the wards - there's an awful divide. A charge nurse can get a Clinical Tutor walking on to

the ward telling him what he should be doing, and then he's gone again, he isn't there to do the work under pressure. Now, I'm not saying he's wrong - I can appreciate his point of view, but I think very often they don't appreciate ours.

Floor: The horrible thing about it is there are too many specialists, not too few, but unfortunately none of them work in mental handicap.

Floor: I think expertise rather than specialists is needed. I think that people in the mental handicap field are very sensitive about, say, general nurses because they have an expertise in surgery and obstetrics and so on. I think this is something that we have to do in mental handicap, to train people to provide expertise as Mr. Brown says - and it is this lack of expertise such as behaviour modification and other things in this area which could help.

Floor: I think it's not the SRN we need to fear, it's other such people as play therapists and the like which are now being brought more into mental handicap hospitals. These specialists which in my day when I trained I was under the impression that it was the job of the RNMS to be the play therapist and the teacher of the mentally handicapped. It seems to me that along the line this is where we are going to lose out by bringing in too many other specialists instead of looking at what the RNMS and the SEN(MS) should be doing.

Floor: If we're not careful there's going to be a few more coming in too and then what we will end up with doing is putting food in one end and wiping the other. I've seen this coming more and more. If you get this lethargy in attitude, this is what is going to happen.

Floor: I agree. What we are tending to do is to bring in people like psychotherapists and physiotherapists and speech therapists - why doesn't the RNMS go and do a play therapist course after qualifying? Then we'd have both the RNMS and a specialist field. This isn't happening at all - it's RNMS full stop and then you get put on a back ward and forgotten about.

Floor: Do we really need to do things like specialist play therapy courses. Isn't the basis for that right there in our own curriculum? Why should they need to go away - surely this is what we should be teaching them?

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SOCIAL EDUCATION AND NORMALISATION

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In 1948 I was appointed education and training officer at a hospital for the mentally handicapped. At that time I think it was a very progressive idea to put someone in charge of what was then completely disregarded, namely the education and personal development by educational means of mentally handicapped adults. The credit for this goes entirely to Dr. C. J. C. Earl who was then the Medical Superintendent and who had been a pioneer in developing the potential of mentally handicapped children who were at that time completely "out of sight - out of mind". I simply continued what he had started on the children who were not sent out of the hospital then because of their 'immaturity', 'delinquency', 'instability' and so on and had to remain in the 'colony' as it was then known.

It was on both Dr Earl's and my consciences that there were people who had been developed quite considerably in the school and who at the age of 16 were transferred to a custodial setting in the colony and were sent to do work as adults despite their immaturity. It was my job to do something about this situation. At that time, the only staff available to help in this project were the nurses and, though I was a complete newcomer to them, many of them realised that this was something new and exciting and something which they felt was the answer for so many of the ex-school leavers (ESN) who had more or less been neglected in the past. Thus it was with the full co-operation of the nursing staff that we developed a training scheme.

At first the idea of a training scheme was to produce a more realistic work situation and so we got rid of the basket-making, rug-making, mat-making and all of these very custodial and traditional occupations in the colony. I scouted round Birmingham to the various factories and asked for machinery so that we could get a realistic sort of atmosphere into the place. So masses of machinery and equipment arrived at the hospital and the next thing was, of course, to go out to the factories and ask them for work. In spite of the madness of the unsystematic approach, we did have an aim in mind and we eventually got there by trial and error. This somehow worked because of the enthusiasm of the staff and because it was something new.

At that time, in the early 1950's, I was thinking of education and training but emphasised training in the vocational sense. But very soon the 'fruits of our labour' returned from having been sent out to work (on what was known as daily licence then) and having failed miserably. This was somewhat of a shock after having put all that work into work training, work habits etc. We did not teach a particular task but the basic work habits, how to get down to a job, do it for so many hours, how to please the employer and so on. However, we found that these people who had done so well in our encouraging, stimulating work atmosphere had

been sent back to us after a very short time, or had run away from the place and came back to us as failures.

Obviously something had to be done about this and so I interviewed every single one of those 'failures' and asked them what on earth had happened to make them run away, abscond, ask for their cards or whatever it was. Gradually out of these interview situations a lot of little incidents began to draw attention. For example, I remember there was one trainee who had done extremely well and had been sent out to work, very pleased with his success at having got that far. During the first day the workers stopped for their break and he brought out his cigarettes, and the next moment the foreman dashed up to him and shouted "Can't you --- well read?" as there was a large "No Smoking" sign on the wall. Johnny immediately asked for his cards and said he was going home and off he went.

And so in one instance the work of months and months had been completely foiled simply because he could not read a "No Smoking" sign. He had not wanted to admit in public that he was a non-reader and so he had left. We realised then that if we had taught him to read "No Smoking" this particular incident would have been avoided. We realised of course that there might be many other situations later on which could lead to similar reactions but if one could do something about these various failure possibilities then at least the first or second week in a new job might be more peaceful and less demanding. Once the mentally handicapped adult was more settled in the job he might not react so dramatically if the strain came later on, on account of an unexpected request.

So out of this analysis of breakdowns in employment came my idea of 'educational first-aid': that you give some relevant education preparatory to a crisis that might develop in the work situation by making the situation more familiar to him and preventing the trainee from breaking down under the strain. Thus we decided to teach everything we possibly could so that we might prevent the trainees from getting into trouble at the most crucial time at the beginning of a new job.

I remember another girl who was at work for quite some time doing very well in the factory. Then one day the foreman told her that, as she was doing so well, he was going to put her on piece-work, and the next day she had absconded. When we eventually got her back again I interviewed her and found that the word 'piece-work' was unknown to her, that she had asked her work mates and was told that you simply do as many as you can and count them as you go along. Well, of course, she couldn't count and rather absconded to avoid the situation than have it shown up in public that she could not count after having done so well.

So we learned that counting too was an important thing and decided to list this skill among the many possible failure situations and work from there. Very soon this list of possible failure situations was as long as my arm and it was obvious that it would take years to teach even this minimal basic knowledge even to these high grade, low dependency people. The next point that I discussed fully with Dr. Earl, my then Medical Superintendent, was that we should not keep our trainees too long in education 'at school' because this would be counter-productive if we

went on and on with teaching without the trainee seeing the rewards at the end of it. We agreed that a reasonable time would be 6 or 9 months and that every 'pupil' in the training scheme should be told at the beginning that it wouldn't be longer than that.

So the second point that arose from this was, that we had to design an educational syllabus - a curriculum which could be taught in a comparatively short time. The third and most important aspect, which was not quite so obvious at that time as it is today, was that huge millstone around our necks - the colony or institution as such. It was a millstone because the institution was primarily custodial and protective. The word normalisation was unknown in those days but I realised that you could not really teach in an overprotective and custodial situation in the way I would have liked to. It was clear that if you wanted to teach the mentally handicapped how to use the telephone in public callboxes you had to give them practice outside, and you would have to have all sorts of things which were against the institutional rules.

It is to the credit of the people concerned in the hospital that they agreed to loosen the rules and were prepared to take responsibility for this. It was all right for me as a psychologist and as the Education and Training Officer at that time, to have all sorts of revolutionary ideas and schemes, but if anything went wrong other people would be blamed. At that time for example we had 'parole' for patients but they had to work for it - it wasn't just given out as a matter of course, but had to be earned. But trainees in this intensive education group were given parole as a matter of course right from the beginning, which they lost if they did not deserve it. Dr. Earl had to face a lot of criticism because this went against the traditional view that parole had to be earned by good behaviour rather than the other way around, that a privilege would be lost if you were not well behaved.

Nurses were involved in the teaching of our patients right from the beginning and one of the 'mod' ideas which came to mind was, at that time, to teach the patients how to find their way around Birmingham, to catch buses, use the telephone, etc. Finally, I took them out in the car to an unknown part of Birmingham where they would be completely lost and told them to find their own way back to the hospital. Then I went back and sat at the end of the telephone in my office and waited very anxiously wondering what would happen, because obviously they could abscond during that time or be run over by a bus and so on. Then gradually they came drifting back, or sometimes I received a telephone call to say they were lost and we had to collect them eventually. The whole education scheme was a very good and very useful way of using education directly to teach relevant skills and even more to establish a relationship with mentally handicapped people. Therapy, patient contact, interaction etc. was and still is generally interpreted as talking to people, asking them questions, being friendly and so on. I don't think that is sufficient. What is necessary is that they see you as going out of your way to do things for them, and I think that tremendous relationships develop out of these situations. All right, sometimes it backfires such as with one chap with whom I had a very good relationship. He was a constant absconder and in those days this was rather a crime. Dr. Earl and his successors faced it quite well but it was something that was not done and someone

with a record of 20-30 abscondings was very high up in the league and the nurses got a bit uneasy about constantly losing this chap. Anyway, I got into such a good relationship with this patient that I could always persuade him to come and talk to me about it when he felt like absconding. This was obviously a good result of the educational scheme. He was one of our trainees, he knew that we wanted to teach him things which were important, and so he always came and talked to me and his absconding was considerably reduced. Then one day, another patient brought me a little note from Tommy in which he said (I can't remember the exact words): "Dear Sir, By the time you read this I have absconded. You see every time I come to you you persuade me not to abscond and now I want to abscond and so I didn't let you know" !! But there was a relationship there and this had come out of education and was one of the great results of it.

By now we had a programme which was realistic and relevant to the future of the people concerned because it had come out of their own failure situations. Secondly, we had a time limit to consider - how much can you teach within a given time? And this forced us to put priorities on what we were going to teach. We couldn't teach reading because this takes years and years, and we had only 6-9 months. All we could teach in this time was 'No Smoking; Ladies; Gentlemen' etc. but we couldn't teach proper reading. As far as number and money work was concerned we were quite satisfied if they could add up, never mind multiplying and subtracting and so on. So, a list of priorities developed which was the second point, and the third point was to adjust the custodial institution in a developmental way to the needs of the person and thus to resolve the conflict of being in a custodial protective atmosphere and yet still trying to assist the trainees to show initiative, independence and so on.

These were the three points which came out very clearly at that time, to which a fourth one was added which arose from my own professional work as a psychologist. This was that when one does something one ought not to know only the aims but also to look out for various pitfalls which arise, where the difficulties are, how fast we are moving, and to cut out wastage. After all we had only a very limited time to teach a person and therefore it was a waste of time to put a particular 'subject' in the syllabus if a particular person knew it already. So out of this developed the idea of what was originally know as the "Educational Attainment Record" and later became the P.A.C. This simply consisted of writing down all a person knew or did not know, and then selecting from the gaps which are shown up in this way those areas one would endeavour to teach, the order in which one would teach it and thus produce a structured and intensive teaching approach. After six months or so, the situation was to be re-assessed to see how far one has succeeded, then instead of blaming always the pupil for not succeeding, to ask ourselves what went wrong with us as teachers, as a teaching environment, as a developing environment. I find this particular kind of educational 'post mortem' is invaluable, and so out of this situation developed my general thesis, that you have to document all the time if relevant action is to commence.

By documentation I do not mean simply a record goes into a file, or is discussed at a case conference and then returned to the file. Now that type of record could just as well not be done at all in my opinion. We spend a lot of time in making accurate and careful records, and it is really a waste of time if this knowledge, which is so laboriously acquired, is not utilised.

I am now going to talk about the PAC and other work which has developed out of this. Take the PAC or whatever social assessment score you choose and use it as a tool for action. Out of the background I have described I developed a documentation tool which is quite clearly designed first of all to make a diagnosis of educational shortcomings. I carefully avoided making this tool into a diagnostic measurement scale ending in a Social Quotient, or Social Age. I felt that it is a deficiency of our assessment techniques that a human being's competence or incompetence is simply summed up in a number of two or three digits. I felt that this was wrong because all you could do with that figure was simply to compare one quantity with another. It did not tell you anything about the quality of a particular achievement. I felt we needed a qualitative record rather than a quantitative one to show exactly what had been achieved by the mentally handicapped person at the time of the assessment, and to show the gaps in his performance.

The second step following an assessment is to take action on the results obtained. I am aware that this assessment is a lengthy business and requires much effort. Unless one uses the record to take action - if at all possible - one should not spend time on obtaining it in the first place. I know there are plenty of hospitals where the PAC is done as a matter of routine, but as far as I am concerned that is nothing but window dressing and I am not at all impressed by it. So, I repeat, if you do a PAC, it should lead to action, and not be just a nice impressive piece of paper to show to the National Development Team when they come round!

Once this record has been obtained the next question which arises is, what do you do with this mass of information which is now available? Well, every person has different deficiencies and different needs of course and it would be ideal to handle them all individually. From the practical point of view, we have the problem of getting groups together where the members have the same or approximately the same needs, so that they can be taught as a group and yet some individual attention can still be given to one or other member of the group. Thus the next thing one does with a record is to use it for designing a timetable for the group membership and to decide exactly what programmes to teach and how to set about it. The programmes have to be constantly adjusted to take into account the type of patient one is dealing with so that what is given is really what is required. Otherwise we are in danger of producing a big educational 'sausage machine' which every patient goes through without paying the slightest attention to the actual personal requirements. Every patient is on the register and after a certain time one can write a report that a certain number have passed out after a course in social education with full credits! I think one has to check on this.

The next use one makes of the assessment is, of course, to have a look at it again after six months or so and see whether any improvements have been made. Here again we obviously have the problem of the severely subnormal who is a very slow learner compared with a less handicapped one, and one has to know what one is achieving, and how much one could reasonably expect to achieve. This problem has been exercising my attention for some time and the solution which I put forward must, I think, be very clearly understood because it can easily be rejected for the wrong

reasons. What we really ought to say is, we have mentally defective people - using the old term, in the sense that there is a defect - it is there. The defect leads to a handicap just like any physical defects produce a larger or smaller handicap for the people concerned. This handicap can be reduced if we do the right things with the person - if we give him a chance to use the educational crutch, or the educational artificial limb which we can give him. So, it is a question of reducing the handicap rather than dealing with the defect. Obviously, the defect is there all the time and this puts a ceiling on what can be achieved in the reduction of the handicap.

The traditional measuring device is always directed towards normality. You can take most assessment tools, and by and large they always refer to the average achievement of the normal population, and the mentally handicapped deviate in varying degrees from that norm. I thought that was a pretty silly thing to do because if the mentally handicapped is a mentally defective with a permanent defect, by definition he will never be normal. Always looking simply at the norm of normal people makes us feel that the mentally handicapped are achieving very little and produces a rather frustrating situation. So, instead of having to chase after something which is unobtainable, so to speak, I proposed that we compare the mentally handicapped with the mentally handicapped. Thus, what we are in fact saying is: 'Supposing we have a group of mentally handicapped people and we give them the best education and training, attention, love, affection, everything they want, and we give this for enough years so that he can be really developed to his full potential, and if we then work out what his attainments are, this will then be the aim - this is what they can do despite their defect!' So the objective must be to have an assessment technique of the average achievements of a group of mentally handicapped people who have by and large the same intelligence level living under the best educational and social and parental and environmental conditions - that will be more or less indicative of what they can do. Then we can measure every other mentally handicapped person against this norm and expect that he should reach this level despite his deficiency, provided we can give him the same educational stimulation and supportive background. Obviously there are other factors which will intervene, such as personality but at least environmental conditions of varying kinds will not interfere to a large extent.

However, we have never done this. We have never given our mentally handicapped people the best possible opportunities for development. Even if they are at home and the parents are really spending their whole life looking after them they will still omit very important aspects, such as the <u>systematic</u> development of the potential.

We come then on to another possibility - we take the achievements of mentally handicapped persons as they are at present with all our shortcomings in treatment and training etc. and then establish the present average achievement levels. Next one looks at all the people who fall below that average, and tries to find out why they are not doing as well as the average - and do something about it. If we systematically look at every under-achiever and commence with successful remedial action then, when the next assessment at a later stage is obtained, the average will have gone up, because the under-achievers will have contributed better, higher scores. In due course with ambition and luck, we could arrive at a much higher average attainment level than we had initially.

The average attainment levels of mentally handicapped people, as shown in the P.E.I. are not stationary but ought to move upwards, for the time being. I am at present interested to find out whether the attainment levels which were averages ten years ago are still valid. In fact I did look quite recently at this problem when studying nearly 800 PAC records of adults in Training Centres in one part of the country. To my horror I found that the averages in the sample of today were well below the average levels of 15 years ago. There are of course various reasons for this and there must be some careful analysis why, in this particular sample, average attainments appear to be worse than before. The point is that attention has been directed to a possible weakness in the system.

All I am saying now is that we have to have at least an idea of what it is reasonable to achieve and that can be done by looking at the average of a large group of mentally handicapped people. Anyone who is an under-achiever by falling under the average of that group, should be investigated. I am not saying that I want all mentally handicapped people to achieve this level because obviously if someone is blind, or spastic and so on then a lot of additional handicaps will appear. What I am saying is that if someone is below our average level then we must find out why he does not do as well as the majority of people and try to assist him if there is no good reason for not doing better.

Once we have done the initial assessment we must continue to look at the re-assessments - the second, third and fourth assessments and ask what has happened here. Why is he still not improving? Why is he still not moving forward? Sometimes the explanation will be : he is emotionally disturbed, so that explains it, but in other cases we will have to admit that we don't really know why he is not improving. We might then ask, well did we really try to teach him this ? And somebody is sure to say there has been "no opportunity" to teach this because we are in a hospital.

What do we really mean by "no opportunity" ? It can be an excuse by staff who simply don't bother about doing things. It can also be something that they quite genuinely can't do anything about because it is forbidden. If, for example, you want to teach good table manners and how to use knives and forks and so on, and if the policy of the ward is not to have knives because it is dangerous, there is obviously no opportunity and the relevant skills cannot be taught.

The word "Normalisation" tends to be pretty much of a dirty word these days. One hardly dares mention it. The concept has come over from Sweden and is associated in many people's minds with doing away with hospitals and institutions etc. I should like to use it in a different way which I think the Swedes would not quite accept. To me, normalisation means that one ought to give people a chance to live as much as possible in a "normalising" environment. I cannot see that an institution or hospital as such can ever be a normal environment. It is more or less a contradiction in terms. But it is our duty if we want to look at it not only as a custodial place but also as a developmental framework to provide within that framework of the hospital as many features of the normal environment as possible which would help in developing the mentally handicapped to a point where they have a chance to experience the world "outside".

I have said "as many features as possible" and I would go further by saying, select those features of normality which will be conducive to development. In other words what I am really saying is that not everything

which is called "normal" should be introduced simply because of this verbal label but that we should be a bit more careful about what we introduce and more sure that it plays a constructive part in the developmental work of the institution.

I will look at normalisation under three headings and would like to define three approaches to normalisation which arise out of the modern idea of social education and training. People in the institution or hospital should be prepared for a) living independently, b) going into a hostel or group home etc., c) if they are not to go out, that they should still lead as normal a life as possible even if they are often very severely handicapped.

There is something that I would call the "window-dressing type of normalisation". In this case you put up a nice appearance and say to everyone who comes round, there you are, we are quite progressive, we are doing very well etc. There is obviously a revolution involved in this. If you tell nurses to come out of uniform, for example, and not be traditional nurses any more, then this is a revolutionary and traumatic step for many people, and is an indication that the hospital doesn't really want to be a hospital any more - it wants to be a developmental place. This is a very good step in the right direction. If the staff are called by their Christian names this is again a different idea of a normal relationship of people who live in close proximity to eachother. So, when I say that this is window dressing, I would emphasise at the same time that it is an important aspect. You don't only have a beautiful window, there is something in the shop behind as well - it may not be as good as what is in the window, but it is not completely different, there is something in common between the display and the actual situation. So if a hospital goes and does this window-dressing normalisation, and has therefore the outward trappings of a good new outlook, then that is good, it creates an atmosphere and an environment which is positive. I am not saying anything against it, all I am querying is whether this is all, whether this is sufficient. It is not - it is one step, even though it is an important step. If one leaves it at that, then do we achieve what we want to achieve ?

We can talk about another type of normalisation which is not so much what the hospitals or social services do, or the community does, and that I would call the incidental type of normalisation. The incidental type of normalisation occurs if you put people into group homes, hostels, or any sort of place in the community, send them to work or the training centre or whatever, so that they will pick up the normal way of living. It is the theory that if you put people from an abnormal hospital environment into the normal environment of the community then they will absorb normal thinking, normal living, normal customs etc. They will do this to some extent, and thus it is obviously an improvement, but we are now collecting enough evidence to show that the improvement due to this incidental type of learning, this informal learning, is minimal, ie: about 5 to 7 percent improvement, and no more.

And then we have the third type of normalisation which I will call, for want of a better word, selective normalisation. By this I mean, if we again look at the hospital as a developmental place, that we take into the normalising aspect of the hospital those features that will help in

the development of the person. We select those normal features from the outside world which are useful. A few examples to make this clearer : It is normal that you go into a canteen, it is normal that you get a plated meal, and many hospitals with central kitchens have plated meals. It is something that you find very often in normal life that you have meals already served on a plate, and therefore you can say it is an improvement in the hospitals as this is normal feature. But it is also a normal feature to have a table which is properly laid and on which you have your vegetables and potatoes and meat and so on, for you to select from and to decide how much you want. This is a feature of normal life which I think is far more helpful for developing the mentally handicapped than if we simply have a plated meal handed out, or people queueing up in a canteen and being handed a plate. So, one tries to select from normal life those features which are helpful and which in one way or another teach the mentally handicapped to do something. Another example : if you ask your architect to build a new ward or unit, or re-model the old one, you tell him that it is for 15 or 20 people who all have to dine at the same time. So the architect goes home and makes his plans and he has looked at your people and seen that they are very clumsy and shuffle around and knock other people over. He produces a dining room which is very large and where the tables are well placed apart so that there is plenty of space to pass through. But you also find in normal life that places where you eat are very crowded, and if you sit down you have to say 'Excuse Me' to that chap behind you in case you knock him over. If he wants to get up he has to be careful not to knock you down. Suddenly in a crowded place, where tables are close together, you learn something else besides feeding. You learn social graces, and to be a bit more careful, and to control your movements and to interact with other people.

Thus I would say to the architect that we only need half that space he has allowed for the dining area. We want to help our people to realise that they have to consider other people. We shall teach them something of this only when we concretize the situation - not when we lecture about it. Why make things always comfortable when in fact you can learn something from not being so comfortable?

Or another example : You have to teach the mentally handicapped what is large and what is smaller - the different sizes of things. Allright, the teacher goes into the educational shop and buys those nesting cubes where you put one thing into another. This is lovely when the child does it sitting in front of you in the schoolroom. Then the child goes back to the ward and though he needs reinforcement there are of course no nesting cubes on the ward - that is the privilege of the school. But you might have a little kitchenette with pots and pans. Pots come in different sizes and there are large ones and small ones and you can learn to fit them into eachother. This is a nice little exercise for someone to learn what is large and what is small and directly related to life. Every housewife knows that the kitchen cupboard is always too small for all the things which have to go in it and you have to learn to stack things so that they will all fit in. If you had a huge cupboard where there was a shelf for every object - well what would you learn? You wouldn't have a useful realistic experience.

What I am trying to put over is that normalisation must not simply be an unconsidered acceptance of anything which is 'normal'. It is something

which we have to think about whether it will help or not in the business of living an ordinary life. For instance, I am not quite sure about calling everyone by his Christian name. It is lovely to have one big family, but if our mentally handicapped youngster goes out into the big world and addresses everyone by their Christian name because he cannot draw the line, then a problem is created not solved. There was also the case of the good-looking, simple minded girl who was very affectionate in the hospital school and everyone loved to be the object of her affection. However, when she continued to shower her affections on every passenger in the bus and kissing everyone in sight a good many more problems were created. Thus, the implications of every 'normal' habit we try to implant ought to be carefully considered. We have to look carefully that the right features are introduced into the institution and that the number of 'No Opportunity' explanations are radically reduced.

In conclusion, I should like to say that one ought to talk to everyone concerned, management most of all, because many of the decisions which are needed in order to get away from this 'No Opportunity' excuse are policy decisions. It is a policy decision whether we have a hot and cold tap; it is a policy decision because someone must take the responsibility, must be brave enough to take a considered risk and face a court action. But how can we ever teach the mixing of water as a normal skill unless we have the right taps? It is a policy decision whether staff can eat with patients at the same table and is not suspected of helping themselves to food which is not theirs.... Now this must all be decided at the= highest level as a policy, considering not so much how to run a hospital economically, nor how to run it in such a way that all criticism can be avoided, but how to run it so that we have the means to develop the mentally handicapped person who is, after all, the centre of our attention.

SUMMARY OF POINTS FROM DISCUSSION GROUPS ON LECTURE

Generally, it was felt that it was historically useful to know how Dr. Gunzburg had developed the P.A.C. His feelings of education and normalisation had reinforced the feelings of the group on these matters. However, practically there are often staffing problems which one can do nothing about, and the problem of staff apathy was hard to overcome.

It was felt that the ideas in the lecture could be applied to individual hospitals by using the PAC and long-term planning of objectives, such as normalising rather than normalisation. Some people from the groups, even so, felt that the PAC did not give a clear enough idea of "what to do next".

The extent to which these ideas can be applied to individual hospitals was felt to be often limited by a lack of resources in the community. Psychologists and psychiatrists often have conflicting views which nursing staff are said to find confusing; in addition they sometimes fail to give support to projects which the nurses start. It was felt that the PAC could be used as a strategy for training but that until the present constraints of the hospital system were removed, a lot of the ideas put forward would be held back.

Those ideas in the lecture which were felt to be impractical by some people in the groups included the following :-
a) Normalisation is often difficult because of the rules of the hospital which tend to be overprotective of the patients.
b) How does one normalise the very severely physically and mentally handicapped ?

c) Normalisation is difficult because of societal constraints.
d) The ideas themselves are not impractical if attitudes are changed, and if we are realistic in our aims to teach the residents to live more independantly within the hospital.

The points which tutors felt they needed more guidance on were, primarily, how Dr.Gunzburg saw the future for them as nurses. Some felt they needed guidance on how to tackle other people's attitudes and how best to get staff to work as a team along with some practical guidelines for action.

The implications for nurse training were felt to be, firstly, a need to train all staff no matter what grade, perhaps with a short course of lectures; to adjust our attitudes on the development of the individual; to utilise nurse teachers for in-service training in order that the learners would have less chance of suffering from the 'school versus service side' difficulties.

Members of the groups felt that the kinds of future research which could be usefully done in this area to benefit the nurse training and service provision in hospitals were :-
a) Training in team work.
b) Training in attitude change.
c) Regular and compulsory in-service training.
d) Education of senior staff.
e) To develop people as multi-functional units, ie: each person taking on many roles.
f) To develop people as enablers.
g) A need for on-going training for all staff.
h) To train nurses not just for the hospital but for the community as well.

QUESTIONS

Floor: What are we normalising for, and what are your views on this problem of hospital and community ?

Dr. Gunzburg: May I start first with a statement? I apologise for talking about apparently obvious things, but is it all that obvious? One of the questions was, how do I persuade people to follow my ideas? - and the answer to that is, I don't succeed. I work in eight different places and there are one or two hospitals to which I just don't go any more. In places we have created conditions where we can get together and we have slowly converted ourselves and influenced eachother, but there is one thing to remember - change takes place slowly. I am probably the longest serving soldier in this room here in mental handicap and I have the advantage of being able to look back and see that one has achieved a tremendous lot, looked at in perspective. If you only look at the last few years, one hasn't achieved anything at all and staff leave and everyone is desperate and gives up. I think what we have to deal with is this fact that we are now in a changing situation, we expect results very quickly and we don't get them, and then you ask quite rightly, how do we change this ?

You refer quite rightly to problems with senior management and the wrong attitudes of staff. This is true, but I too have problems with getting the ward staff to accept my ideas. Quite frankly, in the old days when I started, it was much easier to put the concepts over and get them done within a big framework. Even though there was a Medical Superintendent and a Matron and a Chief Male Nurse, you knew your bearings, but now you have all sorts of other influences. So my answer is this - it's a constant battle but one can succeed. If the rules don't help, get them changed, simply that. Therefore this depends much on an agreed philosophy carried through by a multi-disciplinary management.

Now, the question you asked me, what are we normalising for? I am fully aware that society and the community isn't ready to accept the mentally handicapped but I wonder whether people who are deviant would ever be acceptable in a community that rejects deviants anyway. So why do we push them into the community? I am not absolutely convinced that the mentally handicapped person, even if he is socialised etc., is always better off in the community. However, we are normalising to give people a chance to say Yes or No to the community. They are the ones who have to reject the community and it is not the community which should reject them. Now the point I am making here is simply that we should not go to a patient in the hospital and say: "Derek, would you like to go to a group home or a group hostel?" - even though he has never seen a group hostel and is terrified. We are a protective environment and because of this our people do not know what the community is like. Thus we must prepare them - normalise them to make them capable to make the choice of whether they want to live outside, or having looked at the outside and tasted normality to say "No thankyou very much, I'll go back to the hospital again." Now that, I think, is our ethical duty - that we do not make up the patients' minds for them, say he is not capable of going out and therefore we really ought to prepare him for here, but that we ought to give him the tools and social skills so that he is not terrified as soon as he is outside. This, therefore, is normalisation. That we give them the chance to reject the community after we have prepared them for a normal life, not that the community is put in an easy position of rejecting the mentally handicapped.

I have sent out people who have been in the institution for 30-40 years. They were trained for over two years before going out and they are now living happily by themselves or in hostels - and none of them wants to come back to the hospital. Perhaps it was our good training programme, or perhaps it was extremely lucky, because I know of other people who did come back. So, this is normalising - to become persons who have choice opportunities and they cannot have choice unless they have the necessary skills.

Floor: How does normalisation apply to the severely and profoundly handicapped?

Dr. Gunzburg: I don't know really - let's be quite frank about it. You see, what we have done in our institutions is to find room by sending out the most capable ones first and then the less capable ones. We have now reached the severely mentally handicapped. We do not know yet how far we can normalise them. On the face of it you look at the profoundly handicapped and you say "My God - nothing can be done with this group". Yet,

sometimes one comes across cases who have given the impression, even to the psychologist with his scientific tests, that they are very severely handicapped. Then some miracle happens and we find a way in and give them these extra abilities and skills to make them function on a much higher level. What I feel is that we are now at a stage where we don't know the answers so we should not prognosticate. I have the feeling that if we change our whole attitude to how we deal with people and what we expect of them, then in due course we will have a different type of person to deal with. He will react to us and he will develop and, whilst still being a mentally defective person, his handicap will be of a different kind, of a lesser kind.

We don't really know what sort of potential there is. One of my colleagues has asked the nurses to pick out the most severe non-communicating adults in their wards, people who were rocking and doing nothing else. He then started training them in communication. All he tried to teach them was their own name, and the names of the people they were in the group with, whether they were a man or a woman and so on. Now after only three or four months of this training they know their own name, they know the names of other people - they are communicating. They are in touch, and to those who have seen these people over the years not taking the slightest interest in any one else, it is a little miracle that you can say: "What is your name?" "What is his name?", and they say: "Jean and Alan". And they establish a contact and sometimes, very hesitatingly their hands reach out and touch another person, and a contact is made. Now, I don't know what is happening - All I know is that they are paying more attention - what the magic is in the package I don't know. But already these very severely mentally handicapped people are beginning to be different persons and I think my answer is that we have to experiment and try to have selected ingredients of normalisation around them. It is normal to talk with other people, it is normal to know one's name and other people's names and this is a direction which we should explore.

Floor: What changes would you like to see in the GNC syllabus or do you have any comments on nurse training?

Dr. Gunzburg: Well, I think first of all we have to ask are these staff going to be nurses or what? May I forget about nurses for a moment? What kind of training would I like to see in people who deal with the mentally handicapped in residential situations, whatever they are. Isn't that really what we are asking? Now I thought I made it clear but let's talk it over again. I think of them as developers, as educationalists. Now this sounds daft in a way because you can ask, where does the teacher come in? I think the teacher has a completely different role and I don't even know whether we need teachers or educationalists as such. What we do need is the person who has got the necessary ability to realise that there is a handicapped person who has to be developed and therefore he must see himself as a developer, as a therapeutic person.

On the continent there is a profession which is quite new to me and they call it 'Orthopedagogue'. A pedagogue is a person who tries to develop the whole person rather than trying to teach him reading, writing and arithmetic. Now if we look at our problem in this way, he will do the assessment which we have been talking about, and he will not ask the question some of you have asked me - what do we do next? I am amazed that you should have asked me - what do we do next? I am amazed that you should have asked this question. Well, isn't that what assessment is about? - Sorry if I put it so bluntly. OK - he cannot wash, or he cannot shave himself and so on as

it says on the PAC - well then, the next thing is obviously to teach him these skills. Now how do we do this? - the Americans have done it by producing a big book where every single PAC skill was listed, e.g. Heading 'He cannot shave himself', and underneath all the various techniques and approaches used in order to teach this. Now when I showed this to a teacher he was horrified, and said 'No teacher would ever look at this book'. But it was produced for nurses! - Now is that the difference? That the teacher would use his own imagination, his own skills and techniques which he has been taught at college, whereas the nurse asks, 'What do I have to do? - A, B, C, D, E.' I think this is where I would like the syllabus changed sufficiently so that nurses are taught to think for themselves about how to teach a task. Give them the teaching techniques, firmly established in their training.

Also, to realise that everyone has to work in a team - this is a curious phenomenon which I watch with great interest and great frustration. We all sit in multi-disciplinary case conferences where everyone makes a contribution and the end result is usually a passing the buck from one to the other. Nobody makes a particular decision. Responsibility seems to be a word which is disappearing from our vocabulary nowadays. I would like it if it were made quite clear in these syllabuses that everyone has to teach, has to take the responsibility for developing a person and not pass it on to another profession. We have been split up into so many professions. We say: 'These are non-nursing duties' and someone else should do it, and then in the end we have a lot of other people doing various tasks, many of which would help in developing the mentally handicapped, and the whole educative process has been passed on to other people, or been fragmented.

Someone asked me to look into the crystal ball and that's a dangerous thing because there you can really go for me if you see what I want to see in the future. But I could see someone really being responsible for the whole person, being sufficiently trained so that they don't have to run around and pass it on to specialists. We must be better trained to look after educational, social, emotional and personal development and not know so much about anatomy and physiology, much of which is probably pretty irrelevant. So these are the changes I would like to see: that people get a professional attitude, a professionalism which makes them accept responsibility for a person as a whole, and not looking all the time at their job description.

Floor: A number of people have alluded to the problem of changing the attitudes of senior staff and senior management and other groups who are not directly involved in the working situation. Do you have any tips for such attitude change?

Dr. Gunzburg: No, I haven't but I think it is very important that the senior management contain at least one or two people who work in the right direction. Psychiatrists, who some colleagues think are great obstacles, can be in my experience very helpful though they really do not produce much input. Psychologists also don't know what their contribution should be in mental handicap. Most of them have been trained to assess and advise on their assessment results but they have not always been trained in mental handicap. Where the psychologist could help is if he were made to take

note of the urgent problem which you have in the ward - in training and educating and developing - and that he is asked to help in that aspect rather than going back to this little ivory tower and writing a nice little paper about various test patterns and so on. But again, why does he not make a greater contribution? Well, very often he is not accepted in the ward - he is not made welcome because as soon as a psychologist turns up in the ward, he turns up with a bit of paper which means (a) assessment, (b) follow it up with a programme, and (c) we shall have a look at it. The nurse will then say: 'Ah, it is all very well, he goes home at 5 o'clock, while we have all the hard work to do with the patient until 8 o'clock.' Now there must be somewhere an acceptance of a professional input which has its own conditions of service, and a willingness to accept this work. You commented "psychologists should show more interest and support" - I agree and if an interest isn't shown and support isn't given then I think that psychologist ought to be fired. You won't find one in my set-up, they are highly selected and have an interest which is to lead to action, to intervention, rather than to a description of conditions, etc. But whether they can give that support - that depends really on the relationship between nurse and psychologist - it must not be one-sided, because they have to learn about the situation, they have to know what sort of input they can give, by working together. I have seen it working very well.

Most of you are tutors and from various comments you made you are obviously aware that the ward staff are not always that supportive and that helpful in developing programmes. This is the whole problem isn't it, that everything we try to do nowadays is a little bit of a condemnation, a little bit of an indication that what has been done before is not right and therefore has to be changed, and so people go on the defensive.

Floor: Have you got any ideas as to the future in mental handicap?

Dr. Gunzburg: This is again coming back to your comments about there being nothing new in what I said. I believe that a corner in the open community will always be required for the mentally handicapped and that that corner is an institution, but that the institution must look completely different from today's institutions. I think a lot of the bureaucratic system should be done away with - we ought to be able to loosen up, to have the whole institution in little units which are more or less autonomous but which are still within a campus regulation. Once we get this and once we learn that people can take responsibility in this sort of situation we can get away from people having to hang on to rules, hang on to regulations, being on the defensive all the time. Now, as to specific things you should do in your own hospitals - now there is no answer to that is there? I would have to sit down with every one of your hospital units and ask detailed questions - but I can't do this so I hope this does not leave you too dissatisfied.

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BEHAVIOUR MODIFICATION IN HOSPITAL AND COMMUNITY

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Let me start off my putting into context various aspects that spring to mind whenever behaviour modification is mentioned. It seems to have acquired a mythology and a mystique that to some extent is unwarranted and needy of de-mystification. This process of de-mystification ends up by a general agreement that in fact it refers to what most of us are doing most of the time during the day whenever we are interacting with another person, whether that person is recognised as being handicapped or not. Whatever we do influences, modifies, changes, alters their behaviour. Also that change in the other person's behaviour has a reciprocal effect on our own behaviour influencing it in turn.

Behaviour modification has been presented as a set of techniques that you can look up in your little book - for example, you look for 'time-out', it tells you what 'time-out' is; you look for 'positive reinforcement', it tells you what 'positive reinforcement' is; you look for 'token systems', it tells you what 'token systems' are. However, behind it all there is a basic philosophy which is much more crucial and important in determining whether or not programmes that can be based on a behavioural philosophy get off the ground and are maintained and actually influence the general way we look at handicap and the way that we deal with the problems that handicap poses.

So, first of all, I want to talk about the basic philosophy of a behavioural approach to mankind, not to mental handicap. We shall extract from that philosophy that which is relevant to us in dealing with mental handicap and I will then sketch in some of the difficulties that have been identified when you try to implement what might probably be a fairly novel programme in an institutional setting. There are also well known constraints that make innovation difficult which I shall sketch in. I then want to talk a little bit about some of the workshops that have been done through the Institute of Mental Subnormality, working with nurses, teachers, psychologists and parents and I want to try and relate these two topics and to show where we succeeded and where we failed. More particularly, perhaps, to show you where we had difficulties and link those back to the guidelines that tell you how to go about making innovations in institutions in the hope that people can learn from some of the mistakes we made. It is pointless repeating the same errors we did. We got involved very early on in the movement and so were bound to make tactical errors which were not apparent at the time but only apparent in retrospect. I will explore some of these tactical errors and hopefully give some guidelines on how to avoid them. If we have time after all that we will look at a video tape of some of the practical steps that were involved in a very basic implementation of behaviour modification principles.

It is really very important to explore the philosophy of behaviour modification. The attitudes or belief system that we have about any

organisation or an individual influences very markedly the way that we relate to that person. Our philosophy about the nature of man affects the way we interact with man a great deal. If we believe for instance that he is a being that has, say, a complete free will and is totally undetermined in his behaviour we react to him in a different way than if we believe his behaviour is determined by the way that we interact with him. There are two alternative philosophies. This particular philosophy very much says that behaviour is determined. It says that what we do - that is, behaviour, the things we do, the things we say - are caused by something, they don't just happen out of the blue. A lot of people believe in the common sense philosophy that what we do just happens - 'his personality made him do it', 'he does it because that is the way he is made'. Well - that doesn't tell you why he does it, it simply couches it in other phrases. If you say somebody hits someone else because he has an aggressive personality you have not really added any further information. It begs the question: 'How do you know that he has an aggressive personality?' The only information that you have is that he hits people! - and so can you see that what you have done there is simply a circular argument of redefining the question in an attempt to explain it?

Very often some of our difficulties in trying to explain, in particular behaviour problems in mental handicap, is because we have merely re-defined it, given it another name. The child runs around a lot and we say he does this because he is hyperactive. He doesn't run around because he is hyperactive - hyperactivity is the name given to the behaviour of running around a lot! It is not the cause of it but a description. This is the first part of the creed, that behaviour is determined.

The next statement of belief is that behaviour is determined by the effects of an interaction. It is not caused by just one event. It is not caused solely by the environment which is what the old traditional behavioural psychology would have you believe. It is caused by many things - it is a multifactorial model. It is important to see that part of our basic belief is that only some of these causes can be manipulated. If you are going to change a person's behaviour you not only have to identify factors that may be related causally to that behaviour but you also have to be able to change those factors. It is no good identifying them if you can do nothing about them. Thus we can make the satement that behaviour can be modified if its determinants can both be identified and manipulated - and that is really the essence of the behavioural philosophy.

By identifying those determinants, we can design an environment in which they can be brought to act towards the goals that we set an individual. It is therefore important to decide what we are trying to do with an individual and how the institutional setting allows us to do that. If you take for instance as an overall aim, developing a person's potential to the full, such an aim does not give you guidelines of what to do since you do not know the nature of a person's potential. You will have come across that statement as being a guideline for practice in nurse care, that you are there to enable this person to develop his potential to the full. How do you know where or what constitutes a potential. How do you know when you've reached it? - it is a very woolly, fuzzy type of term that gives you nothing to hang on to so that the notion of helping someone develop their potential is of little use.

We have, therefore, to look very carefully at some of the statements we make when we're talking about a handicapped person. It is easy to make excuses and dodge the issue by saying that if that patient fails to learn to communicate it is because he lacked the potential to learn to communicate. You can even sophisticate that by getting a psychologist to come in and test that person's so-called potential and he can say, he has only got 32 points of it, and we call it intelligence. That does not add any information either. Psychologists have perpetuated this sort of mythology that there are measurable quantities in people that determine whether they learn things or not. It is probably a myth. Instead of saying we are trying to encourage someone to develop their potential we have to look very objectively at what we are trying to do. It looks as though at the moment the most acceptable approach to take is one of enabling people to become independent. We want to design an environment that gives them the experiences that will allow them to develop competence in the skills that will enable them to be independent people.

Now that seems a fairly acceptable way of looking at what we are doing with anybody, whether or not they are handicapped. The difficulty with handicapped people is that they are very much slower at acquiring those skills. We have therefore to design a much more efficient and effective environment in which they can be enabled to become independent. Some people would disagree with this - they would say that as we are dealing with handicapped persons we should provide them with all their needs - they need washing, they need dressing, they need feeding, they need stimulating. Now that does not enable somebody to become independent. That care approach will keep someone going, keep him alive and happy, keep him what I have heard described as 'amused and amazed', but it will not enable him to become independent. It is a matter of argument whether we take independence as our long term aim - we happen to have done that. You then have to look at the institution and its practices and ask whether these help or hinder the development of an environment in which people can become independent. I shall highlight that point later and point to some practices which run counter to the idea of helping people become independent.

One major component of the approach when searching for the causes of behaviour is to look at the 'setting conditions' - what sets you up to behave in a particular way, what are the 'antecedents' of it, what comes before the behaviour, what precedes it. This model encompasses the fact that people differ because of their genetic make-up, because of variation that is encoded genetically. It is very difficult to see how we can manipulate that. We can identify it and you can see it very clearly in things like physical characteristics, but the evidence is controversial whether your ability to learn, your ability to change your behaviour through experiences has a genetic component. There is currently a major discussion about intelligence - is it inherited or is it acquired? It really is a nonsense argument because it is an interaction of the two. Even if we identify a genetic component as a source of variance in our behaviour, we cannot manipulate it. As yet there is no way of doing genetic behaviour modification through genetic engineering. There may well be a time when you can interfere with someone's DNA structure and change, alter and modify their subsequent behaviour - may be, but not at the moment.

There are anatomical factors related to the behaviour that an individual develops and the ones that are perhaps more relevant to us are those

to do with dysfunctions in particular systems, dysfunctions of input systems and of output systems. You have people who suffer visual and hearing handicap that influence their behaviour. We can do something about designing means of compensating for these. People who wear spectacles, for instance, have prosthetic devices that compensate for an input dysfunction. If you take your glasses off your behaviour is modified, influenced, altered, disturbed. The same with hearing aids. Output dysfunctions such as follow from cerebral palsy where people find it difficult to manipulate the world can also make use of prosthetic devices, like POSSUM.

There are physiological determinants which affect the way you behave. The longer we sit here, particularly those who have had two or three cups of coffee after lunch, the more sensitised you will become to certain internal changes that are occurring that will determine certain behaviour patterns that occur around tea time. You must be familiar with the diuretic effects of caffeine. Therefore physiological change too is going to influence and determine your behaviour. A lot of behaviour modification in institutional care is done by physiological manipulation - tranquillizers for instance. Medication is a procedure of changing somebody's internal physiology such that their overt behaviour is changed.

Then, finally environmental determinants of behaviour. That is, the situation in which we are tells us which particular behaviours out of our repertoire to select, because they are appropriate behaviours to show in that particular place. The technical jargon 'discriminative stimuli' simply means that we learn to discriminate the presence of certain cues in the environment that say in effect, now is the time to behave in that way. This room is a very powerful discriminative stimulus to set me up to talk non-stop. If I went and stood in the middle of Newcastle and talked non-stop, it wouldn't be long before I was put somewhere else. I would be showing a piece of behaviour under inappropriate discriminative stimulus control.

The environment includes not only its physical component but also people. We can determine which behaviours the people we are caring for - the handicapped population - actually show. You will know that that is true because if you have worked on a split shift you will know that the residents on one shift can behave differently than when they are on the other shift. They are exactly the same people - all you've done is change the discriminative stimuli, put them in different setting conditions.

All of these factors interact. Some we can manipulate, some we cannot. The final determinant of behaviour is historical. Experiences that happened to us in the past will affect what we do in the present. That is really quite crucial because we sometimes have to explore the past experiences of a person so that we can interpret what is happening now. The problem with historical data is that you cannot manipulate it. You can manipulate what people say they feel about things that happened in the past but you cannot change their past experiences. Many schools of psychotherapy have been founded upon what I would argue is a fallacy - that if you simply explore somebody's past history you can influence their present and future behaviour. I think what you have to do is look at what is happening to them in the present and try and change some of those things, so that their behaviour will be influenced.

Finally, in this model, there are consequences to behaviour. Things happen as a result of what you have done and some of those things that happen as a consequence make it more likely that you will repeat what you have just done. We can refer to those events as 'strengthening events' - other events make it less likely that you will repeat what you have just done and we can refer to those as 'weakening events'. In the technical jargon there are terms to describe those events. They are known respectively as reinforcing events and punishing events. I think it is clearer to consider the relationship between behaviour and an event that follows it in terms of: 'Does it make it more likely that that person will repeat that piece of behaviour?, or does what you've just done make it less likely that he will repeat that piece of behaviour?' When you are looking at it closely you are trying to analyse the effect of the interaction between people in terms of making a guess as to whether they will repeat behaviour or not. Let me give you an example in a child who head-bangs. We find head-banging distressing - I think we must all agree that if we see a child head-banging we find it unpleasant and aversive, and if we can do something that will stop that behaviour you are likely to repeat what you have done because you have removed something unpleasant. One very effective way of stopping head-banging that we have probably all found for ourselves is to pick the child up and cuddle him - to 'love' him better. That is a very effective way. The trouble is that it may well be that what the child learns in that interaction is that in order to get you to pick him up he has to head-bang. It may be that you also learn that if you give the child his dinner first that stops him head-banging; you may learn that if you give him a biscuit, that stops him head-banging. I'm sure that we have all had experiences like this. It is a circular trap and you do not actually notice that it is happening because we are hooked on the immediate effects of our actions and forget that interactions have long term effects - that the child may in fact be learning. It is a very effective teaching procedure - to provide something immediately and something that will reinforce the behaviour. The child is learning that head-banging leads to consequences that actually strengthen the behaviour even though the effect of them is to stop it in the short term.

Making that sort of interpretation goes under the heading of doing a functional analysis - it simply says, let us analyse the function of that particular piece of behaviour. What is the function of headbanging? In some cases you can analyse that the function of headbanging is such that it achieves reinforcement from its environment. Therefore you have to design some intervention programme.

Given that that is the basic model within which we work, we then have to see how we can implement this. Remember, it is a very prescriptive model - it is a very much more objective one, it states its aims, it states procedures and it makes the actual work much more clear. It also makes clear the long term objectives, that is - to develop independent living skills.

In order to do that I will try to pull together some of the needs that might exist within a nursing context in hospital care in order to implement this type of approach and to develop these independent living skills. It need not be nursing staff - it could be domestic staff, driving staff, people in charge of transport, people in charge of laundry services -

all of these people have a part to play in deciding whether or not your system will allow independent living skills to develop. One of the things I have found in some institutions for instance was that many of the residents, even the most competent ones, might never have seen an egg arrive in its packing - its shell. The reason for this is to do with the catering staff who say it is the cook's job to break eggs, to boil them, or fry or scramble them or whatever else they do with eggs. So the residents see eggs as a sort of yellow substance in an aluminium tray. We had to go to a lot of trouble to get the egg from the stores to the living unit still in its package. This energy should not have had to be spent but if it was not spent then an egg would still be a yellow substance in an aluminium tray to the lads with whom we were working.

So how do you change organisations? Organisations tend to be self-perpetuating. It is like a fly-wheel; once you have it turning it is very difficult to change it. Ward management practices need to be organised to emphasise the needs of the residents rather than the institutional routine. That is a very glib statement but we have to explore what it implies. I think we have all been caught in a trap of the routine of the institution and finding the routine prevents us from doing anything about training the residents to be independent. The institution would never say that that was what it was set up to do. If you begin to look at it, just ask yourself what opportunity do you have to teach a man of twenty years to shave himself? You have a single sex ward of 25 young men and two staff. What chance does that institution give you to teach each of those young men to shave themselves? First of all you have only one razor and that does not work, so you're stuck. You try to get a razor for each of those young men and are told there is not enough money. The organisation imposes all these problems over and above those posed by the needs of its residents.

When we talk about deprivation in institutions we often think that if we play the radio all day or provide a colour television and a carpet on the floor - particularly one made in squares so we can lift up the soiled pieces, that we have dealt with deprivation. But deprivation is much more insidious than that - it is failing to provide people with the opportunity to learn how to do things for themselves. If you have to dress all your residents because they have to be in the industrial unit by 9 o'clock in order that they can pack all the Christmas cards in boxes because there's a contract to get out by the end of the week, you are providing a tragic form of deprivation by washing, dressing and feeding those individuals. The time should be made available in the organisation such that you have time to implement independence training.

One of the most common things people say is: yes, it is all very well, we could do this if only we had more staff. Now I think that is right but it is not entirely right. You can have hundreds of staff and you still would not be getting an environment in which people could learn to be independent. At the very worst you would get very neatly folded blankets. It is not entirely growth of numbers of staff that are holding us back, it is to some extent the organisation of those staff. Group nursing instead of block nursing is a very simple procedure that takes a little to get sorted out. It looks as though it is more sensible to allocate a small group of residents to one of the nurses than to say that you all have shared responsibility for everybody. You have to spread yourself thinly

amongst thirty people instead of concentrating on five people. It is also not only manpower resources, it is the physical environment that needs to be improved to provide realistic settings for the teaching of independent living skills.

All the cookers have been taken out of the wards. Now why should that be? That has something to do with the catering and domestic staff, they tell me. It is also done to prevent exposing people to danger. If you expose people to danger then someone will get hurt, and somebody might then take proceedings and there will be all sorts of trouble, so if we cut out any possibility of people taking risks, then we will avoid any of these scandals. By taking away risks from people you deny them the opportunity of learning how to switch on a gas cooker, or strike a match. How many of us are prepared to take that risk with someone we know has a history of epilepsy? Give them a match and say: 'go and light the cooker and when the water is boiling I want you to lift the kettle up and pour it into the teapot. A great risk to take - but unless you take that risk that individual will never learn how to make a cup of tea. We have to balance the two sets of things up.

Finally, the development of skills within the staff. Training of nurses must include, in my opinion, a behavioural basis for teaching new skills. I can think of no other way of doing it. Skills are not acquired by some osmotic process. You don't just acquire them by magic - you are taught them. So if you want people to develop skills you have to develop personal competence in your ability to teach. One effective way of doing it is to do it in a behavioural model. In other words, break it down into its small steps and reinforce it in order to maintain it. If you look at the GNC syllabus you will find that within it you have sufficient leeway there to include a fairly extensive programme that would encompass all these aspects. It will tell you how to organise a ward such that independent living skills can be developed and maintained. It will also give you guidelines on developing behavioural intervention programmes. But what happens in some nurse training schools? They believe that it is more important to learn about artery forceps instead of, for instance, developmental check lists. The practical work in nurse training schools can too often be provided by a dummy in bed. You learn how to prepare somebody for a lumbar puncture. None of this happens these days I am sure. Most people now are involved in developing community awareness, knowing how to interact with parents and how to give guidelines for developing self-care skills.

These therefore are the major needs. We need to look at institutional setting to find why it is difficult to implement some of those needs. Let me give you some suggestions as to why that might be. First of all, I am pretty sure we grossly underestimate the abilities of the individuals with whom we are working. We are not aware that they can do the things they can do if you give them the opportunity to do it. That should be very obvious to us because it is probably within everyone's experience that when you take your residents to Butlins, they are a different group of people. You lift them out of the ward and you put them in Butlin's and they are changed people. They know how to use a knife and fork, they know how to queue up and collect their food, they know how to sit at a table, but in the institutional setting they are not always given the opportunity to practise some of these skills.

We fail to implement training by systematic means. We use exposure methods - 'sitting alongside Nellie' - she'll show you what to do. So you sit there and Nellie does her little bit and the other person is supposed to learn how to do it by a process of diffusion - skills diffuse from areas of high concentration to areas of low concentration! It does not happen. We have to do it by systematic means. We must remember of course that we can systematically give people experiences of, say, toileting and they still will not learn. You must have toileted some people thousands of times. You take them along every four hours, pop them down, if they do something, all well and good, and if they do not, never mind - it is because they are incontinent. You try to develop some sort of routine or habit. Now this is counter productive - it is not going to develop continence training in these individuals but it will keep them dry. I suppose a better example is at night when you do night lifting. You could say, nobody is incontinent on my ward at night and you have only to look at the procedure that is maintaining dry beds to see it is because you have lifted everyone every four hours. Nobody in fact has been toilet trained. They have all been routinised to lifting every four hours.

We need to get skilled in assessment. As a system we have relied on experts for too long to do this "We cannot do assessments because we have no psychologist." "We cannot do communication training because we have no speech therapist." - It is nonsense. People can acquire the skills and information from anywhere. Once you have it you can fine it up by getting people in to spend perhaps a little longer looking at things like assessment and make your skills better, but you do not have to rely on experts. Assessment is really just a very systematic way of doing an observation. You also need to know a little bit about developmental procedures. You also need to know about task analysis - how to break down a particular skill into its sub-components so that you are actually teaching things in the right order. That is all you need basically to know on assessment. You have to do it a little bit better than saying "We do a 12 months assessment," and you write in the notes "Seems to have improved." "Has shown some progress." If you think of somebody coming in new to the situation he does not know how the patient has improved - from what to what? There has to be a much more systematic assessment.

Training Skills

We have to develop our own personal competence and I will show you on a tape a little of some of the very basic personal skills that a group of nurses on one of our training courses developed.

The development of independence is important. The development of community care is important. The view that we hold of the learning ability and the future role and status of handicapped persons in society is also going to affect how we do things. How do we implement such changes as these in institutional care? How can we go about making change? In other words, how does innovation work, what steps can you take that help or hinder innovation? From my reading it looks as though some of the problems we have of obstacles to innovating, say, a behaviourally based programme are that at the moment we have too few people who are skilled in behavioural analysis. The reason is that it is not yet fully integrated into training courses. There are very few psychologists who have had in their training a really good grounding in behavioural principles - and you would imagine that psychologists ought to know a little bit about learning because that is supposedly what psychology is about. The skills need a lot

of further work - we need to do a lot more workshops, seminars, practical sessions, just fining up our own particular skills.

The question then is, how much of that do we teach people and to whom? We work within a hierarchical system, so does that mean that everyone in that hierarchy needs to become skilled behaviour modifiers? Do you all have to become skilled at functional analysis and task analysis and implementation and evaluation? The answer is No. You need one or two people who are the co-ordinators, say, of a team of therapists, trainers, nurses. Whatever you want to call that person it must be someone who has direct contact with the client. You need a number of people who really monitor that sort of programme. I will try and draw up a structure whereby I can begin to see glimmers of this happening.

The other question we have to ask ourselves is, how do we maintain these skills? How do we maintain, within an institution, any change that happens? When we first tried to demonstrate that behaviour modification might work with a group of children we really made two tactical errors that are now apparent. The first error was to do it in isolation of the rest of the hospital - we set up a special unit. There are many people who have fallen into the trap of setting up a special unit: "We will call that the Behaviour Modification Unit and the rest of you carry on doing whatever you were doing". Remember, the interpretation is that even what they are doing is some form of behaviour modification albeit perhaps not very efficiently. You set up a special place, a place where visitors go - "We have our Behaviour Modification Unit - go and have a look at it." Everything is happy now. The next fad might be to set up a unit for Social Activities. Thus everything is in little isolated pockets. I would argue that they are really doomed to failure.

The second tactical error we made was to pick as our clients the most difficult ones in the hospital. That is very tempting to do because you can say: "Well none of you have managed to do anything with these, look what our magic can do." So we do things with them and can actually demonstrate this, but it is a long, time-consuming process and it really is not the best way of going about it. There are very strong arguments for picking the ones that show the most promise first of all so that you begin to generate some immediate success. The danger you run then is that people will say: "Well we could have done that anyway." So then you ask why they did not.

Organisational obstacles

First of all, institutions have routines. It was mentioned earlier that the routine of an institution takes up a lot of time and you can often find that the most highly trained people in an institution are the ones who spend most of their time maintaining the organisation. Who fills in the time sheets? Who does the ordering of supplies? Who does the days off, the holidays, etc.? It is probably the most highly trained person in that setting . That is my observation, that institutionally-oriented activities seem to occupy the people with the most training and the most competence, and the client-centred activities in an institution tend to be delegated to the people with the least training and possibly, though not necessarily, the least competence.

There are also role/job demarcation problems. Who does what with whom? I have listed five different areas of work that we found could

interfere with the development of independence because of potential demarcation disputes.

1. The nurse: This is the person who has the skills and competence and wants to do things which often run counter to the domestic side. The nurse says: "I want to teach this young man how to wash up" but cannot because the domestic says: "That is my job."

2. Transport: How can the hospital transport system interfere with the development of independence? You may be told that nurses should not drive minibuses. That is the job of the drivers. But there are not enough drivers. So we could find ourselves with a lot of minibuses dotted about and nobody can use them. Either the nurse has to be off duty to drive them, or there have to be more transport people employed.

3. Catering department: The cook insists on making the toast. It is therefore very difficult to see how you can teach a young lad to make his own toast. How can he learn to boil an egg if they are already prepared in the catering department?

4. The teacher: "I do my work as a teacher between 9.30 and 4.30". In the bad old days what would the school do when a child wet his pants? Send him back to the ward. What they now do is use that as an opportunity for developing competence in toileting. There clearly needs to be very close co-operation and overlap between teaching and nursing staff to maintain continuity.

5. The therapist: This is another role that is appearing. They do music therapy and hand out tambourines. They do drama therapy and recreational therapy, even horticultural therapy. You can probably call anything therapy - we used to go to the extreme of saying: "You can go on mini-bus therapy today. You might then employ a mini-bus therapist. Would this get over the problem of demarcation? How many of us have been involved in a "walk-round-the-orchard-therapy" - "They are a bit high today, take them out for a walk. - We can't the walk-therapist is on holiday!"

You have these potential difficulties of job demarcation which again are going to prevent the development of individuals. Somehow we have to encourage people to work together. We do not always own a bit of therapy that is ours exclusively. I think it may be that people are unsure of the territory on which they are working that makes them build these demarcation barriers around them.

Organisational change.

The rest of my presentation has been heavily influenced by a paper by Dr. Nick Georgiades in the book "Behaviour Modification with the Severely Retarded" (1975). His is the last chapter in the book and is called "The Myth of the Hero Innovator and Alternative Strategies for Organisational Change." (1) What he says is, I think, very apt to some of the things that

(1) In: Kiernan, C.C. and Woodford, F.P. (Eds.) (1975) Behaviour Modification with the Severely Retarded. Amsterdam: Elsevier.

we have been trying to explore this afternoon. He says it is a fallacy that, since a system is made up of people, in order to change that system all you need do is change the people. In other words, we need more training. Georgiades points out that this is a fallacy - "you cannot change the system solely by educating the people in that system".

You must have seen this happen when a student nurse wants to implement change at ward level. They come up against: "Don't come here with those fancy ideas." "I've been running this ward for the last 30 years". "I'm not having you interfere with it." The system, the routine, its historical precedence, effectively counters any possible innovation. Georgiades makes two main points and a number of sub-points.

First of all, he says, we must ask the question "Who is the client for innovation? Is it the individual, whether or not we call that individual the patient, the learner, the Nursing Officer, the Administrator or whoever. Is he the client or is the system the client?" He suggests that we ought to look at the system and the way that it works. That is the "client" for change, for innovation. He also points out that change is a lengthy process and gives data that in organisations you have to have a time span of something between three and five years to implement any innovation. Now that is much longer than many of us have thought of making change. Perhaps the longer you have been in the business the longer you think it will be before change is going to take place. That may well be so because you get seduced by the system, but it looks as though it is probably right.

He goes on to say that one of the first things you need to do if you want to make changes in an institution is "cultivating the host environment". - It struck me that what you have to do is till the ground properly and if you do that, your plants will flourish, to extend his metaphor. If you start scattering the seed all over the place, in other words trained people, then they are not going to survive. This is one of the problems we found with the Joint Board Course - we were unable to till the ground, to work in the institutions and the settings from which the people came. We could teach them to do things but when they went back they found it very difficult to put them into practise in their home settings.

Furthermore, Georgiades suggests that one should work only with those parts of the organisation that are supportive of change. Find out where people are actually willing to change and will support innovation. We sometimes make the mistake of trying to deal with the most difficult problems first and he epitomises that by saying we must not chase after lost causes. That is sometimes hard, to say 'No, you're a lost cause, just carry on as you are'. That is difficult because often a lost cause, is the one which you identify as having the most need and so we get seduced into feeling that we ought to deal with those with the most apparent need. But he suggests that we should look for those where the support is the highest already and work in healthy parts of the system. He suggests that we should produce what he calls a 'critical mass' - once you have a critical mass of something then it becomes self-perpetuating. A self-sustaining team of workers- this is the idea of where a team comes in - that it is not just one person that can produce innovation, but a group of people because they give themselves solidarity and support and that will to some extent infect other individuals within the system.

Fourthly, he says you must work with autonomous people - people who have had sufficient power devolved to them so that they can make independent decisions. One major problem with a hierarchical system is that it does not lend itself very easily to devolving power downwards because of its structure. The Charge Nurse has to ask the Nursing Officer, the Nursing Officer asks the Senior Nursing Officer, the Senior Nursing Officer asks the Divisional Nursing Officer and so on, and one day an answer will come back "Yes, you can go out to the theatre" - but you've missed it. That fortunately is an extreme example of delay produced by long chains of command. Somehow, you have to devolve the power to give autonomy to the people who are actually doing the job. The best way that we have found of doing that is physically to lift the staff from off the hospital campus and put them somewhere else. That is a subtle move and it is also expensive. We were very fortunate, we had to move from one of our wards following a fire. This ward was right in the middle of the institution with all the institutional practices and we were being hampered in our plans to develop independence training with the residents. We were able to use a building that was right off the campus. It had been previously abandoned because it was too expensive to run. Everybody was moved out and all sorts of things then were possible because we were out of sight of the organisation.

The fifth point Georgiades makes is that you must enlist support from key personnel, those whom he called the resource managers. They need to know what is going on in order to support you. They give acknowledgment or permission to innovate.

His sixth point is that you must protect the team from stress. Now I am not quite sure how he expects one to be able to do that apart from, say, the person who is doing the innovation must also be the one that is the protector. He is the one who is going to carry the can when things go haywire. Someone must assume the role of the can-carrier and it has to be one of the members of the team. It should not be somebody in the hierarchy who is miles away. If it is somebody who is miles away they will be reluctant to let you do things on the shop floor because they will be afraid of you doing something that they were not fully aware of but for which they can be held responsible. You must make the people on the shop floor accountable for their particular actions. The procedure for doing that, he suggests, is the procedure of team meetings. When you look at the way shift structures are designed it is difficult to see how you can get team meetings to occur. At the very worst the shifts never overlap. When you've got day-on day-off shifts they very rarely overlap. There might only be one day when both shifts overlap in the whole week. It is difficult to get any team cohesion. It may be that we have to look a little more closely at the role of one or two key people on that shift system. Georgiades suggests that the Charge Nurse might work days and act as link-man across the shifts.

These are examples of some of the situations that may pose all sorts of problems. I have tried to expose some of the difficulties that we have had though there are many others. Now I would like to explore one of the ways we are currently trying to solve some of these problems in the hospital services for the mentally handicapped in Devon.

We have a Sector Executive Team with the responsibility of determining policy for the mental handicap sector within a Health Care District. The team has four people on it each representing four resources. This is how I think it is slightly different from traditional management structures because we each have some form of co-ordinating role for a resource that

can be brought to bear upon the clients, the residents of our institutions. The resources are a) in nursing, we have the divisional nursing officer there who is accountable to the sector for providing nursing services for implementing whatever policy we decide; b) medical resources, we have the consultant there because he manages the medical resource; c) we have administrative resources, the back-up services, so we have the sector administrator there; and d) the resources of training and rehabilitation which is where I come in as psychologist. I speak to the sector, to these other three, on matters of training and rehabilitation. In this way we jointly set a policy. Each of us are mutually accountable to each other as well. I have to account to the sector administrator for spending money. We spend money on equipment and so on and we impinge on his porters, drivers, the catering staff and so on. Some of these problems I've mentioned earlier on. I work very closely with the DNO because he manages the largest manpower resource - he has the most pairs of hands within the system and so we have to make sure that our policies agree with each other.

We also have a Training and Rehabilitation Team and I now want to tell you about its constitution and membership because I find it an exciting team with which to work. We have someone from the nursing side - one of our first mistakes was to take only nurses who were involved in the training departments - a nurse who was running the social education unit. We have a social education unit with a ward sister in charge. It became apparent to us that we also needed someone from the service side to ensure continuity of training. We have occupational therapists, industrial therapists and they are organised from the OT by the person who represents that side of the training organisation. There is a social worker because part of the remit of the team is the rehabilitation side of moving people through the system and out into hostels. However, we have recently become a little less enthusiastic about Local Authority hostels and have begun to explore the use of group homes that are still within the organisational orbit of the hospital. It may sound odd to do that but it may just be a local problem that Local Authority hostels can be more institutional than the pre-discharge units that we have in the hospital.

We have the voluntary co-ordinator who sits with us as well because, again, she has resources and pairs of hands coming in. We have an administrator, an important person to have - not the top administrator but one of his colleagues. He can tell us what financial resources are available. We have a parent as a representative of the clients. The Parents' Group nominated a particular representative. We have the Tutor Organiser of Further Education. He has educational resources to call upon - teachers, local colleges, colleges of further education. We have a Charge Nurse responsible for Internal Employments. Part of the industrial work training programme is that we have a number of work teams attached to catering, driving, gardening and so on, and the Charge Nurse for Internal Employments reports upon the work training or work experience group of individuals. There is also a psychologist who happens to be me. I am also the representative from the sector so I have a dual role - being responsible to the Sector Team for training and rehabilitation.

However, the most important people on this team are two of the residents. They are elected members - they held an election in the social club one Tuesday evening, and Kenny and Desmond were elected. It has been a revelation to us to have Ken and Desmond sitting on this training and rehabilitation team because they are as good at sitting on committees as we are. Their job is to go round the hospital as they represent all the people who live there, and they come to us and say :'Look, why haven't we got this'; 'Why haven't

we got that'; or 'You're doing this and we don't like what's happening there'. They come up with a list of various items for attention. Sometimes they are apparently trivial and sometimes they can be quite crucial, having an effect throughout the whole of the system as to how we should go about setting up training and rehabilitation.

That is the context within which this particular project was set up. In our whole sector we are aware of a number of individuals who, through historical reasons, are living in the hospital but who should really not be living there. This must be quite common to a number of institutional settings. When you do a survey of levels of competence as we did throughout the sector, you will most likely find some very competent people still living in hospital care. It is anomalous that they should be living in hospitals and not living outside. As Ken said to us at one of the very first Training and Rehabilitation Team meetings : "Why can't we live in a home like everybody else ?" And that I think was a very subtle and yet hard hitting profound question. One of our pilot projects has been to try and answer that, and we found that firstly, there are not many group homes yet, and that ward environments do not always provide the setting whereby you can learn to live as in a home.

(Dr.Williams presented a film on behaviour modification at this point.)

DISCUSSION

Dr.Williams: First of all, we are still working under some institutional constraints, the most obvious one being that it is a single sex unit. We are still having problems of getting over the principle that social training involves mixing of the sexes. I am sure that we will get there one day and that we will teach people the social skills of interacting with people of the opposite sex, but whilst you have segregated units it is not going to happen. You have to set it up and you have to run the risk that there will be problems. This is the start of a project by taking a group of people outside of the hospital campus and seeing whether or not we can engineer more everyday living. It seems easier to do it off the site than on the site. It still is not perfect.

Floor: How long had these lads been in the institution ?

Dr. Williams: They all came from the special school within one of the hospitals. Most of them were admitted there when they were about 6 or 7 years old. The average age of these residents was about 22, so I suppose we're talking about 14 to 16 years average stay within institutional care. The lad Bobby that you saw doing the formal academic assessment - colours, shapes and sizes - you will remember seeing he was able to put things in rank order of sizes which was quite remarkable because people did not think he would be able to do that. He came out at the top of the social competence assessment that we were doing. The commentary mentioned a social training assessment record - Bobby came out at the top of that. We were going to take people from the top and refer them through the community department to move into Local Authority hostels. He was the one that brought home to us the fact that we were over-training our lads if you looked at hostels as the place to which they were going to move.

He went to the hostel with his parents - we have parent's meetings on this unit which I think is very important. We put aside a Sunday afternoon every three months when the parents come along and we go through the programme with them and show them tapes of what has been happening. Bobby's parents were asked to go along with Bobby to the hostel and when they did they came back and said, "no," they did not want him to go to the hostel - that he was far better off staying in thevery unit that was supposed to be preparing him to move out to a hostel. There is a paradox there. At the hostel they were doing all the cooking, they were making all the beds for them, and he was going back to being in an institution. So you have to look carefully at where you are preparing individuals to be independent.

Floor: Why could Bobby not go home to his parents ?

Dr. Williams: I would not put pressure on any of the parents to have their lads home. Bobby is a man of 24. I have not lived at home since I was 17 so I do not see why I should put pressure on the parents to have him. It would not work with Bobby's parents anyway because they have expressly said that they did not want him to live at home for a number of reasons. I think that they are right but for the wrong reasons.

Floor: Where do ethics committees come into this ?

Dr. Williams: I was asked that over lunchtime, about ethics committees. There have to be some guidelines published, and to some extent you might think they are not very realistic. They may suggest that we have regional committees for ethical consideration. Some hospitals have set up ethical committees but I think that that divorces the ethics from the actual day to day work, which you cannot do. - It is part and parcel of the actual programme itself. We would include considering the ethics of what we are doing within the remit of this particular group. It would be part of the role and function of the training and rehabilitation team to consider the ethical implications of any programme that we were going to put into effect. The minutes of this meeting are always discussed at the sector so that if we are going wrong there are other people who can pull us straight. I do not think it is necessary to have a specific ethics committee separated from the general training or policy committees.

Floor: Don't you think the parents and residents by being on your committee, cover the ethical side ?

Dr. Williams: Well I would like to think so. I am sure they do, but then that is a value judgment. I think it is right to include parents and residents when you are discussing the policy of the institution that is supposed to be providing their care. It may not cover the ethical side - we may be hoodwinking ourselves into believing that it does. Your programme ought to be designed bearing in mind that there are ethical implications in whatever you do.

Floor: There again, considering these people are actively involved, wouldn't it be an idea to have someone from completely outside to sit on these meetings ?

Dr. Williams: We would hope that the outside influence of someone like the parents is sufficient, and it certainly was at Bromsgrove, where we had a parent on the policy group. They used to say: "Look, what you're trying to do is at the moment a little bit advanced in its thinking in that the parent group aren't really up to thinking like that yet" - and this was particularly so with sex education for instance.

Floor: How do the parents feel about the training programmes you put their children through?

Dr. Williams: We showed that tape to the parents, and the parents of Simon who was the lad making the tea. They said they would never allow him to pick up a kettle because he has a history of fits. Now that puts us in a cleft stick, because the parents would not give us permission to allow him to pick up boiling water, but by not allowing him ever to do it he is not going to learn how to handle hot things, how to cope with danger. The person who would carry the responsibility would be the team that determines the policy on that particular unit which is a subsection of the training and rehabilitation team. Remember when I talked about devolving power as far down the system as possible, it is the unit team who determines the practices on that unit within the guidelines set by the training and rehabilitation team. So I guess collectively we should carry the can, but I am not sure what would happen in practice if it were put to the test. There is no established case law as yet.

Floor: Can I ask your views about this risk factor? Would you as far as possible try to minimise risk by using equipment, for instance, that is say less dangerous than others. I'm thinking, for instance about the kettle which is a particularly hard kettle to pour out from, for one thing. Also the toast making - they could use a toaster. The fact that there are crowds around him there are the kind of risks you would try to eliminate in the factory situation, say, or would you go for a fairly large risk because that may be the one he may be exposed to in, say, a hostel or if he went to live in the community ?

Dr. Williams: I think those are the kinds of questions we have to ask ourselves when we set out to do this type of project. We can only work within the resources we have. My personal view would be that one takes as much risk as possible consistent with being able to provide adequate supervision. Now that may be stepping too far and I think we may get our fingers burnt by doing that. The alternative is to take no risks and to wrap people up in cotton wool. Now somehow we have to find something between those two extremes. I prefer to err on the riskier side than on the safer side.

Floor: I think the problem here is whether in fact it's a calculated risk or not, rather than just an open risk. You can calculate some of the odds, possibly. The other fact that is going to hit us is when the Health and Safety Act comes in in October this year - we're going to be clobbered then, I think.

Dr. Williams: You mean that the staff are not working in particularly safe circumstances let alone the residents that we are trying to expose to some sort of risk ?

Floor: The residents also come under the Act and I think that when it comes out and we get individual safety representatives appointed who inspect departments and safe procedures at work, I can really see we will get some problems.

Dr. Williams: I would like to think that it would depend on how you interpreted the legislation and that if you have a group of people who were prepared to accept the responsibility jointly and support each other by taking the legislation to mean that you can enable people to have risks, then you can do it. You see, a mother takes an enormous risk the first time she lets her child cross the road by himself. You have to do it though. You cannot always hold the child's hand, so you have to take that risk, and it is the same with our residents. This harks back to what I said earlier - if we persist in refusing to allow them to do things that are potentially dangerous I think we denormalise them.

Floor: One of the arguments that I've had thrown at me against that is that you know the problem is that the mother is not bound by the Health and Safety

Act and of course we are. I'm not arguing that as being right, but it is an argument that's being tossed around.

Dr. Williams: I think that as long as we are aware of what we are doing and that we have exposed the fact that we are aware that it is risky, but that we are prepared to take that risk because our stated aim is to enable people to become independent. If we carried the kettles around for them they would never learn how to do it for themselves. I am sure we will get caught out sometime.

Floor: It's right we should get caught because in a sense this area is a test case. If this is not a new responsibility, a new role for this type of residential establishment it is important that new proceedings are developed.

Dr. Williams: We try to establish these new procedures as precedents.

Floor: This is a point which I think Georgiades made, but when you were talking about innovation earlier it is almost inevitable when you have innovation you have backlash, and it is important that people realise that that is going to happen. Of course, this is an innovation; mixing the sexes is an innovation, you are almost inevitably going to get some sort of backlash sooner or later.

Dr. Williams: Yes, I think it really is very important to be aware that you are going to have things going wrong, not to say; "We didn't think that was going to happen". To be aware that public opinion will probably be against you. Public opinion was very much against us in Bromsgrove when we first started doing health and sex education classes for the residents. But when people see that it is done responsibly and by responsible people and in the full knowledge of everybody else, then public opinion changes. It is really a fear of not knowing what is going to happen. I think as long as you are public about what you are doing and not afraid to say 'we are venturing into an area that is really uncharted', then there is some justification for doing it. But it is a tightrope that you venture on. It is far easier to live a quiet life and do institutional care, isn't it, but this is not what we are in the business for.

Floor: Could I ask about nurse training ? It seems that the model you put on the board enables the idea of nurse training or staff training to take something of a back seat to the need to develop a new living unit or new plan of action. How do you see training ? Would you say that the first job is to develop a new system of care and then to train people to it, or can one in fact train and hope the new system of care will follow ?

Dr. Williams: From what I have said, it would be correct to interpret that my belief is that you get the system right first, and that is the direction that we are taking now. You get the system such that it will maintain people who will then have ideas of doing something different. I would like to think that a system like that would enable it to happen, that somebody at, say, the social education unit level, can come up with a new idea that they would like to try and we can explore it amongst all the people there, and then, because the system is right, the system will support them to put that into practice. Then they can develop the skills to do it. On the training side, we give experience of sitting on this committee to learners. A learner attends that meeting so that they are aware of the sort of team approach to setting up policy and setting up programmes. Learners have that sort of committment, and then the theoretical component, of course, is discussed at the nurse training school in the straightforward lecture course.

Floor: Who does this lecture course ?

Dr. Williams: I do some of it - the behavioural component of the GNC syllabus and one of the tutors does the basic psychology component of the syllabus. We do a behavioural component in each nurse training school as well, and we tie it up to the work that they are doing in the practical setting. I think that is important to have somebody doing lectures who is also involved in the practical setting where they are working. Then you can actually work alongside somebody and also discuss it at a theoretical level with them.

That leads me into talking about the Joint Board Course. The history of this Joint Board Course and why we got involved in it goes back to the original setting up of the behavioural assessment unit where we made those early tapes. Because the unit seemed to be working reasonably well and because there were a number of people wanting to come and visit and see what we were doing, we decided to put on a number of workshops. We started off by doing 3-day workshops where people would come and work alongside us for 3 days and in that time we would give them a number of lectures, we would give them some role-play, we did some practical sessions and they did some ward visits and they read a few bits of the literature. You could get over in three days some of the essence of a behavioural approach. We could also de-mystify behaviour modification. A lot of people had got myths about it that it was to do with Smarties and electric shocks. We de-mystified it. We said that it is really part and parcel of everyday life, and in three days we managed to do that with quite a number of people.

We also did "visiting workshops" where a group of us would go out to other hospitals at their invitation for two days, and again just do an introduction to the sort of approaches that could be possible. Not to say, this is the way you should be doing it, but this is the way that we have been exploring the use of these principles. We would do a day's lecture, and then on the second day we would do the practical work in a ward setting. We felt that it was really quite important that the people who are doing the tutoring roll their sleeves up. We would go and do toilet training and dressing and feeding on a ward. Very often we were presented with their most difficult individuals. They thought: 'We'll test them out, we'll show them', and so on. We used to be astonished at how quickly you could in most cases get some change to occur. We could show that quite a number of people that perhaps they had given up with, could begin to learn to do things. Whether these were maintained or not was another matter and that began increasingly to worry us, that we were providing people with a taste of what they could do but were not able to follow it up.

Parallel to the work we were doing, the Joint Board of Nursing Studies was setting up an outline curriculum for behaviour modification for nurses for mentally handicapped. We decided to run one of these 6 month courses, the entry qualification for which was that people should have RNMS. We advertised and got not a brilliant response, I must admit, and we selected, out of the people that applied, seven for the course.

The first week of this 24 week course was an introductory theoretical week where it was formal lecturing. People would sit and we would talk to them which is not a very efficient way of getting information over. The next five weeks were spent on each of three different settings - five weeks in one setting, five weeks in another, five weeks in another. The three settings were 1). the behaviour assessment unit where the tapes were made where we were dealing with a small group of children in a fairly luxurious setting with a high number of staff - one to one in most cases, doing self care skills, early communication with children, working with parents. 2). The second place where people worked was with adults on a self help skills training unit where we were doing virtually the same sorts of programmes - developing personal competence in basic self care, but with adults. 3). The other unit was in

the psychology and communications centre at Lea Castle Hospital, Kidderminster where again children were worked with and again with parent training programmes. These were the three basic practical settings.

During this time, one afternoon was put aside every week for theoretical discussions and for care reviews. Data were collected on a particular client that was being worked with and was presented in a case presentation.

We then had a week together where projects were presented. Then we had 6 weeks back in the home setting to try and see how much of what they learned would carry over. That was a very difficult thing to do and we found that it posed all sorts of problems because these people were going back into a fairly hostile environment in some cases. In retrospect it was very naive of us to think that it would be successful, we should have spent more time preparing the host environment for receiving these strange beings. One or two people survived fairly well but they all learned something. They all came back with valuable experiences.

Then we had a few more weeks of 'debriefing', of final preparation of the project, and each person presented a detailed case study of a client they had followed through and a detailed review of an area of literature. It surprised us that nurse education does not set you up to look at the literature. All the tutors on the course were psychologists and therefore reared in an academic tradition. An academic tradition means that you read the literature, summarise it and draw conclusions. We found that nurse education in not like that at all. People were not very familiar with how to read things, how to track down literature or how to summarise it. We felt that was quite important to know how to look at the literature because there is a vast amount of information there.

Floor: Yes, so much so that I've started to set my own library up now and I'm encouraging students to look at the literature, but I'm having similar problems, that they don't look.

Dr. Williams: When you get a Nursing Mirror you look for vacancies! Next job up the hierarchy but not the invited papers in the middle. That is a generalisation but in general I would guess that practitioners are not set up to read the literature and that is unfortunate because there is a lot of literature and it is not all written in jargon. - Some of it is written fairly sensibly and its worth reading. So I think, if anything, we helped people explore the literature.

Then the people went back into their home settings after six months. I would say that of the 7 people that we worked with for 6 whole months on this project, that only 2 are still involved in developing training programmes that are behaviourally oriented. The others found it very difficult and I think for the reasons that I posed earlier about innovation in institutions, that if you do not prepare the host environment properly then this odd-being that comes back is ousted and is not welcomed. Any other courses like this really must look very carefully at the way that the reception committee is organised for the person who returns. It would be nice to think that they had been provided with some valuable skills that would enable the residents in their institution to develop some level of independence but again, the institution, the system beat us and it is something that needs to be looked at very carefully.

Floor: I think that one of the modules that should have been included was a good 10 day course on hospital politics because that's the way you survive - you know where to draw support from.

Floor: I think perhaps I'll just present an anecdote to illustrate one of the problems. One of the senior personnel at a meeting on one occasion said that this was complete nonsense and he was very surprised that I tolerated this and sent my learners onto these wards. He said "Its absolute nonsense", so I said "What do you mean?". So he said, "Well, our pupil nurses are taught that a patient went to the toilet, pulled his trousers down, pulled his trousers up again and then wet himself. And he had a reward for that. It is absolute nonsense and its got to be stopped!"

Dr. Williams: Well nonsenses can and are perpetrated under the guise of all sorts of things and you can call it behaviour modification if you want to make excuses for poor practice.

Floor: One of the misconceptions I find needs going into and I'm sure other people will find it as well, not only the ward staff but also tutorial staff, is that behaviour modification is the same as habit training and apart from explaining the consistency of the training, how do you get round it - say from the familiar habit training realm to the unfamiliar realm of behaviour modification? Is there any guideline to do that ?

Dr. Williams: Habit training is a repetitive performance of a particular piece of behaviour by rote, and I suppose the best example is the 4-hourly 'sit them on the toilet, whatever they do, even if they are not wanting to be toileted'. You see, we are always involved in behaviour modification, whatever we do. Habit training is an inefficient form of behaviour modification. An approach to training that is couched in behavioural principles is slightly different. It says that what we are looking at is enabling that person to acquire sufficient skills so that he is independent of another person. Now that is a long way different from habit training. With habit training somebody has to be setting you up to do things and take you there. Behaviour modification, or the training on behavioural principles, develops a person much further than a mere habit, and it should get them to the point where they can begin to organise their environment so that they are in charge of their own learning. That may well be a long time for some of our individuals but I am sure that we have reached the point where we have sufficient skills to organise our own learning - that is why we are here. You are not here because of a habit.

Floor: There is one thing that has come over to me in the last two or three years that's signficant which is that behaviour modification is a practical skill and the only effective way of teaching it is in a practical setting. You can't set someone in a classroom and teach it to them. Now when you do that, that's when you run into all sorts of problems.

Dr. Williams: Yes, but there is a bit more to it than simply a practical skill and techniques. It is important to explore the practice of it and it may be sufficient for most people to be fully conversant with the practice, because that makes you very competent teachers and trainers. But where some programmes have gone wrong is that they have done that without also having access to somebody who is aware of the philosophy of it as well. I think that is important - you need to have somebody who is fully conversant with the theory and the philosophy behind it because you can start doing things in practice that are quite wrong, and do it out of ignorance.

CONTRIBUTIONS BY CONFERENCE PARTICIPANTS

TOWARDS BETTER TEACHING : THE USE OF TAPE-SLIDE PRESENTATIONS

Mr. John Lewis

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The use of synchronised tape-slide presentations in Schools of Nursing can result in reasonably professional productions which eliminate many of the disadvantages of commercially produced packages. One major disadvantage that remains, however, is the fact that each time the slide changes the viewer has his visual awareness interrupted albeit for only a brief moment. However brief the interruption it does prove to be distracting and leads to a lack of visual continuity which to my mind can affect the amount of information which is taken in and retained.

There is a system available which allows the presenter to retain a visual image on the screen for the duration of the programme and it is this system I would now like to discuss. Basically, the equipment required is two automatic slide-projectors capable of using the 'carousel' type of slide carrier; a stereo tape-recorder which is capable of multi-tracking; and a dissolve unit which controls the two projectors and balances the projected slides from each. If your training school already has two projectors, these can be quite cheaply adapted to take the input from the dissolve unit. The adaptation will need to be made by a competent engineer, but it is very quickly done.

The secret of the system is the dissolve unit which is simply an electronic device capable of generating two different sound frequencies and varying the intensities (or loudness) of each. Each of the sound frequencies controls one of the projectors.

To explain how this works is perhaps a little complicated, but in essence what happens is that the sound frequency for the first projector (projector 'A') causes two things to happen to the projector. Firstly, it controls the intensity of the light that projects the image so that when the sound is quiet the light is switched off, and as the sound increases in intensity the light grows gradually brighter until it reaches a maximum. As the sound decreases in intensity the light gradually fades until it is switched off. Secondly, the sound frequency can cause the projector to change slides but it will only do this when the lamp is switched off. This means that the slide change is not visible on the screen.

The same thing is happening with the second projector (projector 'B') except that it alternates with projector 'A'. This means that as the light intensity from projector 'A' decreases, that from projector 'B' increases and reaches a maximum when the light from projector 'A' is switched off. While projector 'A' is changing the slide, projector 'B' is projecting its slide on the screen at maximum intensity. The process then reverses itself and projector 'B' fades off and changes its slide while projector 'A' increases the brightness of its image on the screen.

The net effect of this is that when the two projectors are positioned such that they project their image onto the screen at exactly the same place, the viewer sees one picture dissolve into the other alternately and always has a visual impression.

To produce a tape-slide programme using this method is basically the same as for a one-projector system, but there are some additional points. The major stage in both methods is the initial planning, and when using two projectors this must be even more carefully done, particularly regarding the photography. Because we can dissolve one slide into another we can take a series of photographs illustrating one particular point, and these when shown can give a sense of visual continuity which adds to the commentary. If the photography and dissolving is done accurately an illusion of movement is produced which can give life to an otherwise flat slide production.

The procedure is very similar to that used in the typical Walt Disney cartoons. As an example of how this can work I produced a tape-slide production of mitosis and meiosis, but the same idea can be used for many situations to indicate movement. Another procedure that must be borne in mind is that because we can dissolve one slide into another, many more pictures can be used to illustrate a concept. The number of photographs that need to be taken and the composition of each photograph must, therefore, be very carefully considered. Apart from these considerations the other stages in the preparation of the programme are the same until it comes to the final stage of synchronisation of the completed programme.

Once all your slides have been photographed and processed they should be arranged in order of presentation. They are then placed in two separate carousels alternately. The easiest way of doing this is to write the number of the slide on the mount and also which projector they will be shown from, eg: A1, B2, A3, B4 etc. The loaded carousels are placed in the projector and the synchronisation can be started. The dissolve unit is connected to the tape recorder by plugging it into the tape input socket of the recorder. Each of the two projectors is connected to the dissolve unit by a separate lead and the dissolve unit is switched to "Record". In the record mode, the dissolve unit produces the two separate sound frequencies which are varied by the synchronising control which is also connected to the dissolve unit. This control consists of a sliding lever which varies the intensity of the two sounds produced by the dissolve unit. At the centre of its traverse the intensity of each sound is identical so both projectors show their slides with equal intensity. As the lever is moved towards one end or the other the intensity of one sound frequency decreases while the intensity of the other sound frequency increases. This means that one projector increases its light intensity and the other fades away. At each end of the traverse, the slider will change the slide in either one projector or the other.

The commentary for the programme should have been recorded on Track 1 of the tape. The tape should be placed on the stereo tape recorder at the beginning of the commentary and the recorder should be set in the multi-play mode to record on Track 3. This ensures that the synchronising signal is recorded on Track 3 leaving the commentary untouched on Track 1. The synchronising of the slides to the commentary is now carried out by playing the commentary through and changing the slides and light frequency in the correct places by means of the control unit. The slide changes are usually decided upon

beforehand and marked on the script or they may be decided upon as the tape is played through, deciding on the best effects by intuition. We have found that it takes at least two attempts at synchronisation and usually more to produce a good end-product.

To check the results of synchronisation the tape recorder is set in the stereo playback mode and the speaker supplied by Track 3 is switched off so that only the commentary is heard and not the synchronisation signal. The dissolve unit is set in the playback mode and you can then watch the completed programme to check for any mistakes that may have been made. If there are mistakes, then the programme must be re-synchronised.

Many special effects can be achieved using the two-projector method and a little imagination. Some of the effects that we have discovered are the following :-

1) Movement. I have already mentioned the use of the cartoon-like series of drawings but the illusion of movement can be used in many other ways. When we decided to make a tape-slide programme about epilepsy we had the problem of demonstrating a grand-mal fit by means of a series of photographs. The problem was solved by simply taking a series of four photographs of our actor in slightly different limb positions, the trunk remaining in the same place. When these are projected rapidly they successfully give the impression of convulsions.

2) Zoom Effect. By means of a series of photographs of the same subject taken at different distances the viewer has the impression of being drawn closer into the picture, eg: a series of photographs of a face, moving closer and closer until only the skin is shown, followed by a photograph of a single body cell.

3) Change of Mood or Subject. If the programme warrants a change of topic, eg: describing one activity and then switching to a different one, the projectors can be used to switch the viewers' concentration positively. This can be done in either of two ways, both of which are successful:-
a) The first method would be to rapidly change from one projector to another as the commentary changes so that one photograph is suddenly removed and the next suddenly appears.
b) The second method, which we find better, is to insert a black slide into the carousel so that the picture on the screen is slowly faded into darkness, which remains for as long as you require, and then the new slide appears. The period of darkness can be covered audibly by either commentary, or more effectively, background music.

4) Superimposing a Caption or Instruction. To give extra emphasis to a particular point, a photograph of a particular caption or instruction taken on a black background can be faded in over another photograph. All that appears are the words that show quite vividly over the photograph and can increase the viewers' appreciation of the point being made. An example of this we used in a programme on the administration of drugs. When we wished to emphasise incorrect practices we showed a photograph of the practice and superimposed the caption "WRONG".

The above are only a few of the effects that can be achieved by using the two projectors. There are probably many more which can be discovered with increasing use and experience. If properly made, tape-slide productions using this system are almost as effective as a cine film or video tape but are much more cheaply and easily produced. The cost of the equipment may seem prohibitive if it all has to be purchased at once, but in most Schools of Nursing existing equipment can be used.

The outlay on the remaining equipment is negligible if weighed against the cost of hiring or buying tape-slide packages or cine films.

What I have described may sound like expensive gadgetry and gimmickry, but I am convinced that it is not. I feel that by the developments which we have made, we have a relatively cheap method of producing a visual tool that produces material that is stimulating, satisfying and above all educational.

(Mr.Lewis showed a selection of tape-slide programmes using the two-projector system that he has made.)

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AN ADULT SPECIAL CARE UNIT

Mr James T. Reid

Clinical Teacher, Manor Hospital, Epsom, Surrey.

Present and future trends in nursing the mentally handicapped.

Present thought on the care and training of mentally handicapped people tends to favour keeping as many as possible in the community, preferably living at home but if that is not possible, in hostels and communal houses. Everything possible is being done to provide them with the amenities required from nurseries and Special Schools to sheltered workshops and jobs. All these expensive forms of care are being supplied in an effort to reduce the numbers in hospitals and to provide communities with as high a standard of life as possible. Looking at this situation from the viewpoint of hospital staff this trend has created and will continue to create, if not different problems, at least very much heightened ones in the areas of training and special nursing care. It is obvious from the very much reduced intelligence and physical ability and the much greater amount of emotional disturbance shown by residents admitted to hospitals in the past few years, that the people the community are willing to accept are the least demanding. Add to this the shift away from custodial care to the present enlightened view of education and training for all residents and it can be seen that the whole concept of what mental handicap hospitals are for has changed radically.

It would have been reasonable to assume that with the reduction in the number of hospital residents that the workload on the staff would have been eased. In fact this has not happened. With the new approach to care and treatment and the extra problems created by the newly admitted residents, not to mention the loss of willing help given by those residents who are now in the community, nurses and other hospital staff have got a heavier burden than before. This has not been alleviated by any appreciable increase in staff.

The G.N.C. syllabus has changed to take into consideration the different type of training necessary for nurses to cope with new methods of care

and the training of residents. It is now up to the hospitals to provide the facilities so that the training schemes for new learners and post-basic training for qualified staff can be carried out successfully.

Trying to teach new skills in the classroom and on the wards is only partially successful. A proper environment is needed where teachers, learners and residents can come together with facilities and equipment which is adequate, and appropriate for the job in hand.

The benefits which would accrue from an efficiently run Adult Special Care Service, or whatever other names it might be known under, are many. Residents would receive the best in care and training and would lead as rewarding a life as their disabilities allowed. Staff would be more satisfied with the job they were doing, knowing that they were giving the best service possible. Work load would hopefully be reduced when residents were trained to do as much for themselves as possible. Nurses should be less harassed because they should have more time and work in a less noisy atmosphere, and this should lead to more personal contact with residents which is a most important requirement. Skills learned in the unit would be passed on to the wards so that the most profoundly handicapped residents would benefit, in time. Ideally, we would have happier, more relaxed nurses with job satisfaction who would pass on these benefits to the residents in the form of time, patience and affection.

History of the Adult Special Care Unit

The A.S.C.U. is not a new project as far as this hospital is concerned. It was first started in 1969 by the Medical Superintendent whose concern was then with the number of residents whose mental capacity or behaviour was such that it precluded them from taking an active part in the normal life of the hospital. These were the residents who rarely left the wards and because of low staffing, received a minimum of attention and stimulation. The unit was set up to provide them with a daily environment which was different from the wards where they would receive a greater degree of individual attention and from people other than nurses. These residents were not ill and it was felt that any personal attention they required could be carried out by non-nursing staff. These people were a supervisor and two assistants and the number of residents was to be about twelve. However, because intermittent interest only was able to be given by the Consultant, and Psychology Department and because funding was small and the exclusion of the nursing department, development of the unit became stagnant. It was not until September 1977 when the nursing department took over the running of the unit that things have begun to improve and the service put into effect according to its proper terms of reference.

Purpose of the Unit

The purpose of the unit will be to accomodate up to 24 residents on a daily basis between the hours of 9.00 am and 4.00 pm. The residents are taken from wards who have a number of "unplaced" people (those who cannot take part in the daily activities provided by the hospital departments due to the extent of their particular disability.) The Unit provides suitable accomodation which is comfortable, safe, easily kept clean and can be used in all weathers. It fosters an atmosphere which is inviting and stimulating and is as much unlike a ward as possible. All avenues are being explored to provide the residents with the most stimulating equipment in accordance with their individual needs, this being the most difficult to decide. It is recognised that the most expensive pieces of equipment, besides being hard on the budget

are not always the most suitable or desirable. All staff are involved in the selection of play items and are encouraged to devise and construct as many of the items as they can, involving the help of other departments where necessary.

The People Involved

A therapeutic team was set up and meets at quarterly intervals. The members represent all the departments which are necessarily involved in the smooth running of the Unit. They are :- a Consulatant psychiatrist (pediatrics); the Divisional Nursing Officer; a Senior Psychologist; a Nursing Officer; all members of the staff. The staff of the unit are :- 1 charge nurse; 1 S.E.N.; 2 ward nurses; 2 non-nursing staff.

The Divisional Nursing Officer may enlist the help of other departments and invite them to send a representative to attend the quarterly meetings. The Senior Psychologist devises programmes in conjunction with the Nursing Staff for the benefit of residents who attend the Unit, helps charge nurses to organise activity groups held on the wards for those who cannot be placed in the Unit. She is also involved with training nurses in the appropriate skills. The Nursing Officer has consented to incorporate the Unit within her own Nursing Unit for the purpose of dealing with day-to-day administrative problems.

The Unit Team

It was estimated that a 1:4 ratio was the minimum requirement to be effective. When the Unit is judged to be suitable for learner nurse training, nurses will be allocated to it as part of their training programme. The Charge Nurse is responsible for the efficient running of the Unit, supervising the individual programmes agreed with the Psychologist, on-going training of nurses in Special Care, all liaison duties and holds a fortnightly meeting comprised of Unit staff, Ward staff, and other interested parties. The Unit comprises two separate buildings close together. The Charge Nurse is based in one section and has with him a ward nurse and an assistant supervisor. The second section has a supervisor, a full time S.E.N., and a ward nurse.

General Daily Activities

All residents require to a greater or lesser extent training in the basic social skills. These are catered for by way of the individual training programmes. In addition to this, various general activities are in operation. Present activities include :-

1) Painting with water colours. Many residents are at present only capable of using their hands to do this but brushes can be used. Paper cutouts made by the staff in an effort to give form, are used to good effect. There are also colouring books for paints and crayons.
2) Colour dominoes, pieces of thick card with two colours painted on them and covered with plastic film, are used to aid perception and gain confidence in competitive activity.
3) Matching cards come into the same category.
4) Sand and water play will be in operation soon.
5) There is a small grassed play area which has the usual amenities, swing, slide etc.
6) A home made disco-bar where residents are encouraged to be disc-jockey.
7) A large tricycle.
8) Sing songs and dancing to encourage socialization.
9) Trips in the hospital mini-bus.
10) A dressing-up area consisting of a dressing table with mirror and wardrobe full of old clothes, used both for fun and to teach grooming.

Estimating the Need

One of the first jobs the Charge Nurse was asked to undertake was to estimate the need within the hospital for this type of care. He made a survey of all the wards, the result of which showed that a total of 154 residents were in this category. However, the number was reduced by half to 74 because it was felt that many of the residents were too old to derive any benefit and some were precluded because of physical weakness, the journey to and from the wards four times a day being too much. With 74 as a base line, the number was still more than anticipated and when a survey was made of schoolchildren above the age of 15 it was realised that during the next 3 years about 20 more names could be added to the list. Some of the people who at present attend the Adult Training Centre and Occupational Therapy Department were also thought to be wrongly placed and would be better off in a less demanding situation. These amounted to about 9 or 10, so the full picture would seem to be that there is a need for a Special Care Unit which could accommodate about 100 people. This is about one tenth of the population of the hospital. Although the District is fairly well-off for Special Schools, Workshops, and Nurseries for the Mentally Handcapped. there is no place which caters for the type of person with such limited ability as we are referring to. It has been suggested that our Community Nursing Officer might be able to gauge the need within the community for such a service so that we could have an overall view of the problem.

Conclusion

In this project I have tried to show three things :-
1) That mental subnormality nursing today is very different from what it was ten years ago, and that nurses are being set much more difficult and demanding tasks. Their training must reflect these changes and therefore they must be given the opportunity to practice the new forms of training and education which the severely mentally handicapped require. This can only be done in an atmosphere which is conducive to learning and this means specially adapted buildings, adequate equipment and a good nurse:resident ratio.
2) That the people who make the decisions have now fully recognised the need and are implementing the changes that are required. Let us hope that finance will not cause too many problems.
3) That we have the people of sufficient calibre who are ready and willing to get on with the job provided they are allowed to do so.

I think that the future for residents and staff looks bright but that there is a lot of hard work ahead for everyone in the field which, hopefully, will produce its own rewards.

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A SELECTION OF VIDEOTAPES FOR TEACHING BEHAVIOUR MODIFICATION

Mr David Savage

Clinical Teacher, Brockhall Hospital, Blackburn, Lancashire.

Synopsis of introduction to videotapes

I have been using Dr. Hegarty's series of audio-taped lectures*for the past four and a half years and I am fully committed to using them. Although the tapes have their drawbacks as far as the learners are concerned because of, for example the monotonous voice, or that they find their attention wandering, I feel these are really only minor problems. The most important factor in the presentation of the taped lecture is the nurse teacher who presents them who I feel must be committed fully to them because otherwise the learners will detect that. Other reasons for my committment to the tapes are that it is the only series of lectures directed completely at the learners in the field of mental handicap nursing, and because they are used nationwide they should hopefully get us all thinking in the same way. The content of the lectures suggests the direction we should be going in nursing the mentally handicapped whether we call ourselves nurses or educators or whatever. It is certainly food for thought for the future. We must be positive and know in what direction we are going.

I supplement my presentation of the taped lectures with various visual aids, the main form being video-tape presentation. I also get the learners to do role-play which I sometimes film to show to other groups of learners. I do not always stop the tapes when I am told to do so but I stop them quite a lot at points which I feel are of importance. I have lately begun to omit parts of the taped lectures and present the topics myself if I feel I can put a particular item over in a way more relevant to my learners.

(Mr Savage then showed a selection of video-tapes on behaviour modification and role-play, made at Brockhall Hospital)

* Educating and Training the Mentally Handicapped Patient : An Introduction for Subnormality Nurses. J.R.Hegarty, 1974, Medical Recording Service Foundation. A series of 20 lectures.

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BEHAVIOUR MODIFICATION FOR NURSES AND TEACHERS - THE USE OF ROLE-PLAYING TECHNIQUES

Miss Judith McBrien

Research Psychologist, E.D.Y. Project, Hester Adrian Research Centre, University of Manchester.

Synopsis of introduction to the video-tape

The E.D.Y. Project (Education of the Developmentally Young mentally handicapped child) at the Hester Adrian Research Centre is concerned with research into the development of profoundly handicapped children and with dissemination of research findings to the applied field.

The dissemination is aimed at teachers and nursery nurses working in ESN(S) schools through the medium of a professional body of people who are responsible for advice on teaching, ie: Educational Psychologists and Advisers for Special Education. EPs and Advisers attend a 5-day Workshop at Hester Adrian during which they participate in running an in-service course for staff in a local ESN(S) school which is currently in progress. The EPs and Advisers (referred to as Course Instructors) undertake, on their return to their local authority, to mount such a course for staff within one of the ESN(S) schools for which they are responsible. Each local authority in England and Wales (105 in all) has been asked to send a representative, and to date 12 Workshops have been run with a total of 60 Instructors. Some of these are now engaged in running their own courses.

The in-service course for staff in schools consists of teaching them a set of behavioural techniques for teaching the mentally handicapped. The techniques are put across in 10 practical sessions, each accompanied by a written manual and workbook. Thus the course can be completed in one term if staff(referred to as Trainees) attend one one-hour session per week.

In the practical session various pedagogic devices are used. The first 10 minutes is spent in discussion of the written material based on questions in the workbook. In the next 10 minutes Trainees are shown a videotaped demonstration of the technique in question (techniques include the use of reward training, prompting, task analysis, imitation training etc.). Trainees are asked to rate the tape on record sheets provided in their workbook. There then follows 20 minutes of role-playing. This is the most critical pedagogic device used on the course. The trainee enacts the part of a child she wishes to work with. She brings her unique knowledge of the child into the role-playing. The Instructor takes the part of the teacher and demonstrates the technique in question by using it to "teach" the trainee a task relevant to the child. They then swop roles so that the trainee plays herself (ie: a teacher) while the Instructor role-plays the child. In this way the teacher first receives a model for using the technique and then practices it on the Instructor. Finally the selected child comes in and the trainee works with him for 15/20 minutes. During this period the Instructor will evaluate the Trainee's performance and give

her immediate feedback on her progress (a micro-teaching model). If there is time at the end of the session, the videotape made of the trainee and child can be played back for extra feedback.

The tape you are about to see shows the second half of a typical practical session. The trainee (a nursery nurse) is on Unit 6 (shaping). You will see her role-playing the child while the Instructor (an Educational Psychologist) teaches her to stack 5 tins. Together they work out the order of steps needed to use a backward chaining technique. You will see them swop over so that the trainee is playing the part of the teacher. The last part of the tape shows the child working with the trainee. Note whether the role-playing has been accurate by comparing the child's actual behaviour with the behaviour ascribed to him in the role play. You will also hear a 3rd voice in the room. That is the Co-ordinator (one of the research team) whose responsibility it is to instruct and give feedback to both the Instructor and the Trainee.

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LET'S GO... - SOCIAL SKILLS FOR THE MENTALLY HANDICAPPED

Miss Rosemary Lee

Further Education Officer, BBC, London.

Let's Go... will be a series of 20 twelve-minute programmes for moderately mentally handicapped young adults. Transmission begins in September 1978. The series will be relevant to the more able 14 plus pupils in ESN(S) schools and the less able in ESN(M) schools, and to adults in Adult Training Centres, hospitals and hostels. The programmes are designed to arouse the interest of the mentally handicapped audience in the practice of social skills in a way which can be reinforced by teachers, instructors, parents and others.

Let's Go... is a joint BBC schools / FE production, planned in consultation with both the School Broadcasting Council and the Further Education Advisory Council. Detailed preparatory work on the series began in the Spring of 1977. The production team and the Education Officers involved in the project consulted all the principal bodies concerned with the care of the mentally handciapped, as well as visiting schools, Adult Training Centres and hospitals and talking to individual teachers, instructors, parents, and mentally handicapped young people. Publicity in "Social Services" and "The Guardian" brought in a large number of letters about the proposed series - some suggesting programme topics, others expressing reservations about the feasibility of a series aimed at such a heterogeneous audience.

(Miss Lee then showed two videotapes from the "Let's Go..." series)

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REACTIONS TO AN AUDIOTAPED TEACHING COURSE

Dr J.R. Hegarty & Miss S.P.Winter

Department of Psychology, University of Keele, Staffordshire.

I want to talk this morning about a series of 20 lectures which I recorded on audiotape and which were released, with an accompanying book, by the Medical Recording Service Foundation*in 1973. The teaching package was intended as a resource for tutors of mental handicap nurses and was based on lectures I had given to nurses at a local subnormality hospital. In 1976, the Department of Health provided funds for a study of this audiotaped lecture course to be made. The work resulting from this grant which has been carried out by myself and Sally Winter forms the basis of this talk.

A word, first of all, about my background. Since graduating with a degree in psychology my interest in mental handicap has focussed upon the teaching and education of mentally handicapped children. Before writing the tapes and workbook I was involved both with an evaluation of teaching machines for severely mentally handicapped children and with a study of the infamous 'Doman-Delacato Treatment Programme' which encourages parents to give stimulation and exercises to their child at home. I mention this because the progressive educational approach of programmed learning and the optimism of the Doman-Delacato approach contrasted with the rather pessimistic attitude to education and training which I found in subnormality hospitals. When asked to lecture to nurses in connection with the 1972 revised GNC syllabus on 'education and training' I found that I wanted to pass on some of my optimism and chose examples of work that seemed progressive. At the invitation of the Senior Nurse Tutor at a local subnormality hospital I began to air some of my views, passing on what seemed to be relevant to nurses' needs.

Looking back, it was really a strange situation. I was fairly new to mental handicap, relatively unaware of the problems of nurses and hence, I suppose, really in a poor position to do the job. However, at the time it was not so unusual. The publication of "Put Away" by Pauline Morris, and "Patterns of Residential Care" by King et al. had put pressure on nurses to move away from a medical model of care and the changes in the GNC syllabus reinforced that, and yet nurse tutors were used to teaching within the medical framework. And being a psychologist did not necessarily help ! The psychology I had been taught at University said little about mental handicap and the psychology content of the GNC syllabus resembled 'university' psychology. Neither did the wards help - where could one find examples of a non-medical approach to give as examples to learners ? Things have somewhat changed since then but at that time there was little for me to go on apart from published descriptions of research projects. Therefore, my lectures comprised

* Now, Graves Medical Audio-Visual Library.

what I could glean from the literature which in my eyes would be useful to nurses in developing a more progressive philosophy of care. In putting the Course together I hoped to achieve three things - a relevant package of psychological and educational concepts; educational skills which nurses could use in their everyday work; and a guiding rationale which would help in moving away from a traditional medical model of care.

Now, what was in the tapes? Firstly, there were six lectures devoted to 'basic concepts' of education and training. What I believed to be basic were, first and foremost, the twin concepts of 'stimulation' and 'deprivation'. Common-sense and a lot of experimental evidence tells us that the developing child only develops optimally if his environment is varied and emotionally secure. If a child is deprived of stimulation his growth will be retarded. It is reasonable to suppose that handicapped children will also suffer if they live in unstimulating surroundings - perhaps more so than normal children. Yet surveys of subnormality hospitals such as those of Pauline Morris appeared to show that they provided very impoverished experiences for children and adults living in them. It is clearly counter-productive to spend too long enumerating the deficiencies of hospitals to staff who will hopefully spend a number of years working in them but I feel it important that trainee staff are aware of criticisms that have been levelled and the kinds of evidence on which these have been based. Another basic concept is that these conditions are not inevitable. Tizard's 'Brooklands Experiment' shows clearly that mentally handicapped children can be cared for in small family groups by nursing staff and that an appropriate programme of activities on nursery school lines can lead to improvement in the children's behaviour and abilities.

The philosophy of the first six tapes is that subnormality hospitals can fail to provide the right environment for mentally handicapped children and adults by depriving them of opportunities to experience an emotionally secure and psychologically stimulating environment. But what can be done to ensure that this does not happen ? Obviously there are many factors at work here, including political, personal and administrative ones. However, for trainee nursing staff there is one aspect which is directly under their control - their own attitudes and behaviour - and hence it is towards these that the tapes are directed. Tapes 7 to 12 aim to get down to the nitty gritty of nursing attitudes and behaviour with three basic questions that, logically, nurses have to ask about education and training. These are 'Who do we teach ?' - all patients or just some of them ? 'What do we teach ?', and finally 'How do we teach ?'

Of course, these three questions cannot be answered exhaustively in a set of tapes, so instead, some basic principles are offered. In answer to who we should teach it is argued, with illustrations, that all patients can learn something provided that an appropriate attempt is made to teach them. No resident ought automatically to be excluded from consideration because of degree of handicap or because previously he or she had failed to respond. For what to teach, it is suggested that nurses learn to use Gunzburg's 'Progress Assessment Chart' and to use the items on this as a 'curriculum'. Whilst there are disadvantages to this particular assessment method, charts in the series cover the full range of handicap from very low to high developmental levels thus providing the nurse with one method for the majority of mentally handicapped people she or he will encounter. The question of how to teach is avoided.

For one thing it is not something you can really explain. For another there is no 'correct' way of teaching. And yet, as Dr.Gunzburg noted earlier, it is a question which frequently arises. My approach in the tapes is to encourage nurses to ask why an individual cannot do something and then to use a combination of task analysis and behaviour modification principles to teach it. I think the problem here is for a nurse to want to teach something and to feel that the ward climate is encouraging her to go ahead. Common sense and personal ingenuity will then soon suggest ways for things to be taught - or if not, local expertise can often be found.

The last eight lectures attempt to look at how the concepts and principles outlined may be put into practice. Behaviour modification and task analysis are discussed more fully and the replication of the Brooklands experiment at Queen Mary's Hospital, Carshalton is discussed in detail. Finally, an overview of the course is presented together with an exhortation to the student to put something into practice on their ward, however small, and to see it through. It is argued that the basic patient-centred approach to mental handicap care which is outlined in the tapes costs nothing for a nurse to implement and is a desirable aspect of care.

Reactions to the audiotapes and workbook

We have adopted to date a four-pronged approach to evaluating the course. We have interviewed learners hearing the tapes as part of their training and we have asked them to complete questionnaires after hearing each lecture. Tutors using the course have filled in questionnaires about the tapes and, in an attempt to find out how much learners pick up from the course we have administered short pre- and post-tests. In my talk this morning I would like to concentrate on the first and second of these - results from questionnaires completed by learners and by nurse tutors ('learners' includes student and pupil nurses; 'tutors' includes any grade of nurse teaching staff and our sample of users of the tapes includes a number of in-service training staff.)

Learners' reactions to the course

From, in the main, two hospitals (a 600-bedded one in the Midlands and an 1800-bedded one in the North of England) we have received over 600 questionnaires filled in by learners after hearing each lecture in the course. These represent the views of over 200 separate learners most of whom filled in questionnaires for several lectures. I shall present replies to each question separately and comment briefly on them. The pattern of replies from the two hospitals is virtually identical.

QUESTION 1. "Did you find this lecture generally helpful?" YES/NO

Response	Mean	Range
YES	95%	80% - 100%
NO	5%	0% - 20%

In this, as in all the questions, the mean represents the average percentage YES response of all 20 lectures. The range shows the lowest and highest percentages of a particular response to the 20 lectures.

Here, for example, lecture number three received the lowest rating with only 80% of the learners answering YES to the question while in a total of six other lectures, 100% of the respondents answered YES.

QUESTION 2. "Were you familiar with the material in the lecture beforehand ?" YES/NO

Response	Mean	Range
YES	31%	0% - 67%
NO	69%	33% -100%

Most people found most of the lectures helpful but a sizeable proportion of the material was not new to the learners. Partly this is due to later lectures in the series revising material covered earlier on but there is also overlap between the content of this course and that of other teaching the learners receive.

QUESTION 3. "Did you stop and have discussions when the speaker asked you to ?" ALWAYS / SOMETIMES / NEVER

Response	Mean	Range
ALWAYS	82%	54% - 100%
SOMETIMES	17%	0% - 50%
NEVER	1%	0% - 27%

This question referred to the author's practice of asking listeners to stop at intervals during a tape for discussion of particular points. Groups of learners generally did this but it is clear that not all the suggested pauses were taken advantage of. However, one or two lectures actually had no pauses at all suggested.

QUESTION 4. "Did you consult the Workbook when the speaker asked you to?" ALWAYS / SOMETIMES / NEVER

Response	Mean	Range
ALWAYS	82%	50% - 100%
SOMETIMES	15%	0% - 50%
NEVER	3%	0% - 28%

In some tapes the lecture was varied by requesting listeners to switch off the tape recorder and read material in the Workbook. Generally, it appears that learners did this.

QUESTION 5. "Did you find your discussions generally useful?" YES/NO

Response	Mean	Range
YES	94%	83% - 100%
NO	6%	0% - 17%

80

A rather more uniform picture emerges from this question. A high average YES of 94% goes with YES responses of 83% or more for each lecture. Learners, then, found many of the discussions useful.

QUESTION 6. "Did you find the Workbook generally useful?" YES/NO

Response	Mean	Range
YES	89%	64% - 100%
NO	11%	0% - 36%

These data suggest that the workbook is a valuable aspect of the series. There is, however, considerable variation between the ratings for individual lectures, suggesting that some sections are preferred over others.

QUESTION 7. "Did you generally feel that the pauses for discussion were : (a) given at the right time?
(b) given at the wrong time?"

Response	Mean	Range
Given at the right time	94%	85% - 100%
Given at the wrong time	6%	0% - 15%

QUESTION 8. "Would you have preferred to have discussions at the end of the lectures rather than at the specified times?" YES/NO

Response	Mean	Range
YES	11%	0% - 25%
NO	89%	75% - 100%

It appears that listeners generally found the timing of the discussions to be about right and these figures appear to vindicate the idea of varying the lecture by interspersing discussions. There are, of course, some learners who prefer discussions to be at the end of the lecture although the variation between lectures suggests that lecture content is a determinant of the number of learners wanting discussions at the end of a lecture.

QUESTION 9. "Were you able to hear the lecture adequately?" YES/NO
"If not, any particular reason?...."

Response	Mean	Range
YES	97%	85% - 100%
NO	3%	0% - 15%

Sound quality apparently varied from lecture to lecture but audibility appears to be generally satisfactory. Reasons given for not being able to hear adequately were usually to do with distortion of the sound output but there also were criticisms that the speaker sometimes spoke too quickly and "did not always make himself clear enough".

QUESTION 10. "Did you think the speaker was talking - TOO FAST/TOO SLOW/ /ALLRIGHT ?"

Response	Mean	Range
TOO FAST	4%	0% - 24%
TOO SLOW	3%	0% - 13%
ALLRIGHT	93%	79% -100%

Speed of speech, therefore, generally seems acceptable.

QUESTION 11. "Did you find it easy to concentrate on listening to the speaker?" YES, EASY/ YES, FAIRLY EASY/ ATTENTION WANDERED SOMETIMES/ ATTENTION WANDERED FREQUENTLY/ NO, DIFFICULT.

Response	Mean	Range
YES, EASY	13%	4% - 27%
YES, FAIRLY EASY	27%	12% - 34%
ATTENTION WANDERED SOMETIMES	53%	36% - 67%
ATTENTION WANDERED FREQUENTLY	6%	0% - 15%
NO,DIFFICULT	1%	0% - 8%

While these figures do not show a totally unfavourable picture it is probably more important to note how few people found listening EASY rather than how few found it DIFFICULT. A common complaint in our interviews with learners was that the tapes were inherently boring and needed livening up by, for example, slides. This point will be taken up later in this talk.

QUESTION 12. "Do you think any of the ideas mentioned in this lecture will help you in your everyday work with mentally handicapped patients?" YES/NO
"If YES, please say which ideas...."

Response	Mean	Range
YES	83%	62%-100%
NO	17%	0%-38%

Perhaps the most important question, question 12 revealed a generally favourable attitude but also large differences between lectures, ranging from 62% YES to lecture 3 (History of subnormality hospitals), to 100% YES for lecture 17 (Training of self-help skills.) This question also asked respondents to say which ideas they thought would be especially helpful in their work. 64% of the questionnaires contained a mention of such ideas with a range from 47% (lecture 3) to 89% (lecture 18 - account of the Queen Mary Hospital replication of the Brooklands experiment). The number of listeners noting down one or more ideas is perhaps a good indication of the effectiveness or impact of a lecture.

The ideas noted down make interesting reading, reflecting as would a projective psychological test, the orientation and interests of nurses in training. At one level it appeared that the tapes had resulted in changes in attitude towards the mentally handicapped as is illustrated by the following examples :-

- "I have found it interesting to learn about educating the mentally handicapped because before I started these tapes I thought it almost impossible."

- "You should not underestimate your patient but give them full help and attention."

- "To know that all patients are capable of learning something helps in trying to communicate with patients."

- "You get to understand the patient and what you might be giving the patient."

- "It made me realise how aloof we are with patients."

At a second level, comments suggested that nurses had picked up specific ideas about changes they could make in their everyday work :-

- "The stages of development can be especially helpful as this will give us the basis to plan a more useful programme on the wards."

- "I liked the idea of one member of staff looking after a few of the patients and having the almost total responsibility for training them."

- "Making a conscious effort to make the wards more patient-orientated and ideas of changing fixed routines."

- "Professor Clarke's ideas about breaking the tasks down."

- "Planning a ward programme and setting objectives and trying to achieve them with minimum cost."

QUESTION 13 asked listeners to comment on the tape they had just heard. Few did make any comments - only 10% of questionnaires contained a comment in this section, but again they made interesting reading. A cross section of opinion is given below :-

- "Tapes should be shorter".

- "Would be better if there was something visual." 93

- "I find that listening to a tape makes my mind wander - it would be better if there was a picture of the speaker."

- "It is a little boring but I find the Workbook very helpful."

- "We should be given more time to read the Workbook ...especially the summary sections."

- "The ideas on the tapes were very interesting."

- "It gave me a wider approach to the idea of nursing the mentally handicapped and some ideas of what to look for."

Some of the Tutors' reactions to the Course

Of 40 users of the tapes known to us, we received questionnaires from 31. 1 of these was no longer using the tapes. Of the 30 users, 6 used the tapes for in-service training while the remainder used them for students or pupils. The primary use of the tapes is given below :-

Use	Number of Tutors
Used instead of lectures	5
To alternate with lectures	13
For the projects and practical work	1
For revision for exams	3
As back-up for lectures and discussion	2
In-service training for nursing assistants	2
Combinations of the above	4

A list of comments on particular aspects of the tapes and Workbook shows a generally favourable response although some users are more enthusiastic than others.

The lectures	Very useful	17
	Fairly useful	12
	Not very useful	0
	Not at all useful	2
The information given	About right	25
	Too advanced	0
	Too basic	6
Amount of detail given	Adequate	23
	Too much	3
	Too little	5
Able to hear satisfactorily	Yes	28
	No	3
Length of lectures	About right	24
	Too long	6
	Too short	1
Number of lectures in series		
	About right	17
	Too many	13
	Too few	1

Which adjectives describe the tapes

Stimulating	23
Boring	5
Neither	3
Interesting	29
Not Interesting	0
Neither	2
Not Repetitive	20
Repetitive	6
Neither	5
Informative	30
Not Informative	0
Neither	1
Easy to follow	28
Difficult to follow	0
Neither	3

Whilst there generally appears to be satisfaction with the lecture series in terms of its overall impact (it is rated by almost all respondents as interesting, informative and easy-to-follow) there is less satisfaction with the level and detail of the information given (around 20% of respondents believe there to be too little detail and for the level of information to be too basic) and with the number of lectures in the series (42% believe there are too many). Around 20% of respondents also consider them to be boring and repetitive.

A crucial question we asked tutors was whether they would use the tapes in future. 22 replied that they definitely would be using them, 6 said PROBABLY, 2 thought POSSIBLY, and one person who was no longer using them had not changed his mind.

One of our main reasons for carrying out the survey was to consider ways in which the course, or others like it, could be improved. The next two questions and the replies indicate firstly, what would be useful additions to the present course and secondly, how audiotaped material ranks in popularity against other media.

QUESTION "Which of the following do you think might be useful to accompany the present series of tapes ?"

Response	Number of tutors
Short Films	29
Set of tests	25
Manual for projects	24
Slides	23
Book of readings	23
More references	21
More detail in Workbook	14

Replies to this question can be taken to mean that any of these would be welcome additions to the present course. A visual component is very much in demand while the demand for tests appears to reflect the needs of the teaching situation. More printed material - readings, more in Workbook, more references, are least in demand.

QUESTION "If other courses on mental handicap were being produced, which of the following media would be best, from your point of view?"

Response	Number of Tutors	
Film	29	
Tape-slide	23	
Video-tape	19	(20 users actually had access to video)
Audio-tape	7	
Film loops	5	

Film, the oldest technological visual aid retains its popularity over video tape and tape-slide productions, but as only 20 users of the 31 had access to video it was in proportion as popular. The cheapest medium and of course the basis of the Course we are discussing here, is clearly unpopular in comparison with other available media.

(These data from both the learner and tutor questionnaires are the preliminary findings todate. A final report will emerge with all the data at a later date.)

What may we conclude from our evaluation of the Course to date ?

28 users (90%) in our sample of tutors said that they would probably or definitely carry on using the course in future. This is our most crucial finding since it reinforces our belief that this kind of Course material fulfills a need in mental handicap nurse training. However, we must not be complacent. Learners and tutors indicate that the number of lectures, the level of detail given and the 'boringness' of the medium all require attention if the Course is to be improved. And there are many other detailed comments that we have received (not reported here) which will need to be taken account of.

Rather than go into any more detail here about our questionnaire findings I would like to consider some more general points about the Course which appear to us to be relevant to the nurse training situation. These are largely opinions which we have formed rather than firm results from our studies.

First of all, both tutors and learners comment that the tapes are good but boring - listeners find it hard to continue paying attention throughout a tape. The reasons for this are, of course, many. Perhaps first and foremost they are to do with the speaker's voice and delivery and with the absorbingness of the subject matter. In addition, people are used to television or to the visually stimulating arm-waving, coughs, splutters or other eccentricities of a 'live' lecturer. But we must not forget that how and when the tapes are given to learners influences their reception. 9.00 am on Monday or 3.00 pm on Friday is not the best time to pay attention, nor does it help if learners are bombarded with two or three tapes in a morning in order to get through them. Another factor is the level of expertise available in a hospital on allied topics. The tapes can be seen as too basic or insulting to the intelligence of the learners if they are already very familiar with the subject matter. A related consideration to this is

the stage in a nurse's training that the tapes are given. The concepts can seem very foreign and hence irrelevant (and so, boring) early on in training but considerably more relevant just before finals when it is apparent that they deal with topics likely to 'come up'. It is, I think, important to realise that the concepts can seem intellectually simple (which they are in the main) to the tutor, but while the learner understands them at one level early in training he or she may not appreciate their significance at a deeper level. This realisation only comes after the learner is socialised into the hospital culture, if it comes at all, as he or she realises the dissimilarity between the approach of the tapes and the practice of many hospital wards. This applies to many tutors too - one said to me "I've listened to these tapes many times and I don't tire of them - this is where subnormality nursing should be going". Another, representing an exactly opposite viewpoint described them as "boring and of no use to learners at all." We must therefore be dealing with something more than the medium and format of the tapes - something to do with the prevailing belief system of the listener.

Related to this is the way in which the tapes are introduced to the learners. It is clear from seeing the experience of different hospitals with the tapes that if the tutor doesn't like them the students are also more likely to dislike them. Of course, the opposite is not necessarily true as any teacher knows - what the teacher is very keen on may or may not be received favourably by the student ! In one hospital, a tutor using the tapes only with pupil nurses offered them in a half-hearted way saying that since they were designed for student nurses, the pupils may or may not get much out of them. And they didn't. He then changed tack and told them that they contained everything they needed to pass the exam (!) - the response of those groups of pupils was very positive. Similarly, a keen tutor will look for ways to reinforce the tapes by arranging opportunities for projects, other speakers, obtaining films and books and even making videotapes in his own hospital. As we saw yesterday evening, David Savage from Brockhall Hospital has a number of videotapes which he has made himself and which he uses in conjunction with the tapes. This doesn't of course make the tapes any better but it does increase the usefulness of them to the learner.

A third and final point I would like to make concerns the future for audiotaped packages like this one. Audiotape without slides is a cheap medium in comparison to others and definitely has a place in teaching. The task of authors and producers of courses is to make the medium more palatable to consumers. How can we do this ? One way would of course be to add slides or film. If the increase in cost that would result were acceptable (it probably would be for slides) there remains, however, the problem of how to illustrate essentially abstract concepts such as 'deprivation' etc. by slides. I am sure that this would be possible but at present I believe it to be a difficulty - easier in film or videotape but harder with slides. John Lewis has, however, shown us a very slick tape-slide presentation on epilepsy so this is possibly not an insurmountable problem.

Another approach to improving palatability is to make a much greater use of the tutor. In the present Course the tutor's role is confined to putting the tape on, introducing it, chairing discussions, answering queries and providing back-up teaching. The Course itself gives the tutor no central teaching role. However, an alternative strategy could use the tutor's teaching skills more fully while yet retaining good points of the present Course. There, the aim would be to prepare a

liberal teaching package consisting of, for example, overhead transparencies, slides, copies of articles, tape-recorded interviews with 'experts' together with link material on tape and in a printed book. A suggested scheme for teaching the material would be given together with suggested tests and practical activities and the tutor would then select components of the package best suited to his own teaching style or hospital situation. We hope to produce an example of such a course on 'Assessment and Programme Planning' as a trial of the concept. It may be that there will come a time when such packages are produced by small teams of people as the Open University Courses are at present. A trend to team-prepared Courses is apparent, for example, at Keele and I think it results in a more sophisticated course. I am sure that tutors would be very happy to use these if they were really well-prepared.

Conclusions

I have tried to outline in this talk the origins of an audiotaped course for trainee nurses and some consumer reactions to it. We believe that packages of teaching material prepared for care-staff training in mental handicap have an important role to play in the development of residential care for the mentally handicapped and would like to think that our research will increase the power and sophistication of such resource material.

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DISCUSSION

Floor : Obviously we can criticise the lecture method, anyone can. You seemed surpirised that the attention wandered - I don't think that this is so much a criticism of the tape as the fact that it is just a disguised form of lecture. The listener needs some alternative exercise to break up the lecture other than just the Workbook. That is why I would definitely agree that it needs to be more tutor-oriented. He needs to have something more to do than merely switch on the tape.

Floor : To get over the problem that there is only one speaker, could you not, when you mention, say, Gunzburg, have a section with Gunzburg talking ?

Floor : Yes, the Open University do this. You have two well-known people discussing a theme. Then the listener is left to find out more or question what has been said.

Dr.Hegarty : Of course, it is so much easier to write the thing yourself and then read it out. But you are right - especially now that we have so many examples of projects carried out in hospital wards. Interviews with Charge Nurses, for example, could show learners what has been achieved and some of the problems.

Floor : I think a lot of the burden rests on our own shoulders as to whether we believe in the message of the tapes or not. I personally do, and I think the t es come over better for that. I think an important factor is the time of the day that you give a tape - I think the best time of day is 11.00 am - after students have 'warmed up' and before they have had a chance to have a heavy lunch. But it does matter how the tutor puts them over and I have also found, since I now know them inside out, that I can miss bits out to suit particular groups.

Floor : Do you have to use notes ? I've just looked at my watch and realised that you've been talking for an hour and it was fascinating. I'm pretty sure that if you'd been talking from notes it would have been boring.

Dr.Hegarty : I don't know. The Graves Library like their tapes to be done from a prepared script. An alternative might be to tape-record a live lecture.

Miss Marshall (Graves Medical Audio-Visual Library) : But then you get all the extraneous noises which can be distracting to a listener.

Floor : I was going to come back to a point made earlier concerning a team approach to preparing courses. And I wondered whether it might in fact be possible to have learners involved in course construction. They would be able to indicate to you where difficulties might arise and how they might be overcome.

Dr.Hegarty : Yes I am sure that is a good idea.

Floor : You tend to get a lot of wishy-washy replies in feedback questionnaires. What sort of suggestions would you make for improving the tapes with the exception of things you have already mentioned ?

Dr. Hegarty : Well, my main problem is what to put into a new set of tapes in terms of subject matter. To me this is difficult - there

are so many things one could do - which do you choose ? And I don't really want to revise this first set too much - the original concept may just disintegrate. I think I would make a new set on the lines indicated - giving the tutor more of a central role. For subject matter, I think assessment is still very important since assessment of a patient helps the nurse to get to know her patient and gives confidence in educational planning. I would like to see an advanced course on assessment which aimed to get nurses to do more assessments and to think about how to act upon them.

Floor : Can I ask about the statistics ? Your data are from interested people who use the tapes. What is the percentage of tapes sold that are not being used and would it not help to get their comments?

Dr. Hegarty : We do not unfortunately know how many have been sold or hired. The best estimate we have is 40 of whom we've had questionnaires back from 31. But I am not too interested in non-users at the moment - for one thing you cannot get feedback from learners who have not heard the tapes and for another you are not sure if they have been given a fair trial. We do of course have some data, as I have shown, from people who are not very keen on them.

Miss Lee (BBC): I just wanted to pick up the point about the desire for visuals. I personally think that it is very difficult to listen to the radio or a tape in a group because there isn't anything for your eye to focus on - the great strength of audiotape is that it can easily be listened to by individuals on their own. We get a lot of people who listen to our language tapes in the car. I was wondering if you could see any of your tapes being given individually to learners for them to listen to on their own ?

Floor : Can I endorse that ? We use them with our post-registration students in this way and in fact they seem to get more out of them.

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AUDIO VISUAL MEDIA FOR TEACHING AND TRAINING: THE CONTRIBUTION OF RESEARCH

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A review of the journals of teacher and medical education indicates a striking preoccupation with questions about the usefulness of the audio-visual media for teaching and training. A very great deal of research time has been, and continues to be spent on studies - often based on principles of experimental design - which aim to answer large, broad questions about educational media: can audio-visual media teach? Can they teach as well as a teacher? Is any one medium more effective than others? Typically such studies attempt to compare learning outcomes when two different media are used: for example video tape and slide-tape presentations; self-instructional audiovision and direct teaching by conventional lecture, and so on. In general this kind of study tries to approximate laboratory conditions, controlling essential variables and using appropriate statistics to test the results. In the main, this experimental research is not particularly illuminating. Over and over again, the results point to the hardly surprising conclusion that people can learn from any medium; however, the better the design and control of the experimental study the more likely it is to show no significant or consistent differences when learning from one medium is compared with learning from another. We can find many reasons for the inconclusiveness of this kind of research, not least that it presents very difficult problems of design: valid controls are often impossible to achieve; in equating treatments between two media there is an inevitable distortion of the particular characteristics and capabilities of each; there is good reason to believe that such studies measure neither the total effects nor the most important ones in teaching and learning.

Fortunately, at the Open University we have never had to justify our use of audio-visual media through research. The initial decision to use television and radio as major media of instruction was based not on detailed research but on a certain reading of the field experience in using educational media and largely on what amounted to political judgement. Our audio-visual teaching media are 'given'; consequently, we have been freed to turn our research effort towards smaller, more defined and - I think - more useful questions such as:

- how can we best use a given medium for a given piece of instruction?
- how do the symbolic coding systems of a given medium relate to what a student learns from it?
- within a given situation which medium is more cost-effective than others?

These questions reflect both the main orientations of the media research carried out in the Open University and the main preoccupations of

Open University staff in their search for effective teaching methods and media. For although the media of instruction are 'given', they are by no means taken for granted. There is continual internal debate about good practice and some attempt to adhere to the original notion that the University should be a 'self-improving system'. The audio-visual media - and in our case, this means primarily broadcast television and radio - are at the focus of continued attention mainly because of their cost. At present, the University spends £4½ million a year on these components of the teaching system - almost 20 per cent. of its total budget. However, when one realises that the cost of producing one twenty-five minute television programme is equalled by the cost of producing fifteen pages of printed material, it becomes clear that the system as a whole is costly. Broadcasting costs tend to be singled out in the first place because they are highly visible: an annual amount is paid to the BBC, who produce and transmit our programmes, by the Government on behalf of the University. The very separateness of this procedure tends to highlight expenditure on broadcasting; production costs of other media - such as print, home experiment kits, face-to-face teaching and so on - are more difficult to tease out from within the overall annual grant of what at present is about £20 million which is paid directly to the University itself. Secondly, however, a related question is often posed about the cost-effectiveness of the broadcast media within our teaching system. Broadcasting accounts for about 20 per cent. of the annual budget, but for only about 5 per cent. of the students' study time. How can we be sure that we are using this very expensive resource in the best, most effective way within the limited amount of time which it occupies in the total teaching load?

Research, even with the given, limited context of the Open University, has given no precise guidance in approaching this question. What is has done is to indicate that we need first to consider the situation and the conditions of learning before we can begin to answer the question. So in the early stages of course planning, we need to spend time considering in detail the needs and abilities of the students to be taught, the nature of the learning events and outcomes to be brought about, and the media characteristics or coding systems most likely to achieve them. It is in this area - the development of interrelated typologies and taxonomies of learning styles and experiences, learning goals and media characteristics - that research is, I think, most likely to develop a useful theory of media instruction. And it is towards this that much of our research at the Open University is directed. Although we have by no means arrived at what might be called a fully-fledged theory, we have at least made a start in defining the preferences of our students for various styles and methods of teaching, and thenature of the learning experience, measured along various dimensions when the media are used in different ways.

So:

What are the ways in which our audio-visual media are used? We have developed a list of some thirty-three uses for radio and television which appear to be particularly appropriate to our teaching system. I can summarise these functions under five major categories. Firstly, the media are often used to teach in ways that would otherwise be difficult or impossible for us: to demonstrate experiments and to illustrate abstract principles or principles involving multi-dimensional space through the use of specially constructed physical models; to demonstrate changes over time

by using animated, speeded-up or slow-motion techniques. Secondly, television and radio can bring to students experiences from life which would otherwise not be available: for example, by providing filmed or taped material of events or observations hard to come by. Thirdly, we use the broadcast media to allow students to develop and practise intellectual skills of recognition, analysis, synthesis, application and evaluation by presenting them with primary resource material, for example, film or tape-recordings of naturally occurring events or of different sources of evidence. Fourthly, the media can be used to change students' attitudes by presenting material in a novel form - perhaps dramatisation - or from an unfamiliar view point. Fifthly, there is a use for these media in guiding and organising students' activities and in feeding back the results of learning activities. Now, using the media in any one of these ways has particular effects and involves particular teaching or learning considerations, which vary according to the specific content being carried, and its relationship to overall themes and aims, the teaching context and relationship of one medium to another within that context, the learning context and the characteristics and abilities of the learner.

I can illustrate some of these different uses and their teaching implications in relation to one particular Open University course, "The Handicapped Person in the Community". This was one of the first courses designed under our Post-Experience programme, although since 1977 the course has also been available to undergraduates. The Post Experience Courses Unit aims to meet the needs of adults who have had practical experience in a given field and wish to develop or broaden their skills and understanding to a higher level. These non-degree courses are being developed in four areas: in-service training for teachers, management studies, community education and health and social welfare. "The Handicapped Person in the Community" was the first course to be presented in the Health and Social Welfare area; the second, "An Ageing Population," aimed at those involved in the care of older people will be available in 1979; a third, "Psychiatric Care and Rehabilitation in the Community" is directed at those concerned with the welfare of people at risk to, suffering from or recovering from mental or emotional disorders, and is expected to be in presentation by 1980 or 1981.

"The Handicapped Person in the Community" is generally acknowledged to be among the most popular and successful courses in the Post Experience programme. It aims to improve professional and social skills in order to help handicapped people to achieve maximum autonomy, and is intended primarily for people whose professional activities bring them into contact with the handicapped - for social workers, therapists, health visitors, nurses, doctors, teachers and members of other supportive professions. It is assumed that most students will be familiar with some of the problems of handicapped people, but that their knowledge may be limited to a particular professional approach or to one specific type of handicap. The course examines professional roles and ideologies and encourages an inter-professional approach to problems. Actual case histories and case files are provided for analysis, and many of them are linked to activities in the printed correspondence texts and broadcasts. The first of these case histories is dealt with in the opening television and radio programmes of the Course.

The initial programme in any course is very important in setting the tone and the standard for a series. To some extent it is also a link for the students with the University, enabling them to gauge the views and expectations of the course team. The first programme in the "Handicapped Person" course had a mixed reception. The broadcast notes which accompanied the programme introduced the handicapped subject of the programme - James Woodward - as a member of the course team, which had planned and produced the course, and described one of the overall aims of the programme as being to demonstrate the achievements attainable by some physically handicapped people. In general, however, students thought that the notes had not given a clear picture of how handicapped James was, and the programme came as a shock to many. Some felt that this shock was healthy, while others were angry at what they saw as an attempt to upset them. In fact, the general aim of the course team had not, in this case, been to arouse emotion but to provide information which would allow students to assess the advice and support available to handicapped people and their families, and the difficulties they encounter at various stages in their lives. Yet it was clear that this rather didactic aim was confused by the rather dramatic documentary style of presentation in the programme. A high proportion of students, particularly in the early part of the course, would have preferred a more straightforward didactic style. This confusion between didactic aim and non-didactic style and the problems it can cause for many students is a point I'll come back to later.

The dramatic approach was taken a stage further in the second television programme which consists entirely of edited extracts from Peter Nichols' play "A Day in the Death of Joe Egg" and which is specifically aimed at attitude change. The Nichols play uses a particular device to relate its effect - the actors role-play sketches within the play to caricature situations faced by parents of a handicapped child.

This programme was rated the least useful and the most difficult of the eleven television broadcasts for the course. Many students criticised it as being "contrived" and "artificial"; others felt shocked and were apparently unable to cope with the emotions provoked by the play; the major criticism, however, was that it was difficult to understand the aims of the programme and its relationship to the rest of the course. In fact, the programme was quite specifically related to the correspondence unit which students were expected to be reading at the time of the broadcast, a unit in which the concept of parental "guilt" is considered and in which different types of parental response are discussed. Unfortunately, even at this early stage in the course, many students were working behind schedule and so were unable to make the necessary connection between programme and text. Moreover, although students were warned that this was designed to be a provocative programme and to arouse feelings which might not have emerged from a more objective or academic approach, this warning was given in the accompanying notes rather than in the programme itself in which there was no academic commentary whatever. Again, the majority of students had not read the broadcast notes before viewing, and some did not read them at all. These two points raise questions about the extent to which the Open University can realistically meet its aims to produce integrated multimedia courses. Over-tight integration and overlocking of components causes problems when one of the elements - broadcasting - is bound to a strict schedule of transmission times. So we have to find ways of ensuring that that component is, at least in a limited sense, free-standing.

This brings me to a final point which emerged in relation to the impact of the dramatised programme. A number of Open University tutors reported that although the broadcast had apparently provoked initially hostile reactions, it had nevertheless provided a quick way into what became a useful discussion of some of the themes of the course, once the tutors themselves had added some necessary context and provided some interpretation of the programme material. We have found that this kind of programme can be an excellent and rich learning resource when used within a group, but that it is often difficult for the isolated distance-learner to cope with and make sense of programme formats which rely on dramatisation, simulation or even role-playing to make academic points. So while useful in teaching skills which can rely on tutorial back-up, within the Open University - where tutorial attendance is not obligatory - we have to be careful about this use of television.

On the other hand, many programmes can and do stand alone quite successfully while still linking in, for additional substance, to the pedagogic aims of material presented elsewhere. These programmes also tend to be easier for individual students, working alone, to use profitably. The third broadcast in the 'Handicapped Person' course was probably the most overtly didactic programme, and was also the one found most useful by students. It was called 'Assessing a Young Child' and its three objectives were quite straightforward. It was intended that after watching, students should be able to

- describe some of the methods used in assessing mentally handicapped children, and their purposes.

- explain the difference between a criterion-referenced and a norm-referenced assessment.

- relate assessment to the setting of educational goals.

The programme shows a consultant paediatrician, who was also the author of the related correspondence text, making an assessment of a young mentally handicapped girl, Kitty, whose case history is one of those provided in the case file for the course. A Gunzberg Progress Assessment Chart which has been completed for Kitty on two different dates, is provided as supplementary material for reference while viewing.

This broadcast appealed to almost all students because of its delivery of hard teaching content which would have been difficult or impossible to present in any other way: in order to be able to understand the method, for example, it was necessary to see how it was applied. It is this combination of pedagogic substance and appropriate use of medium which not surprisingly, results in the most highly used and appreciated programmes within our teaching context. There is always a certain tension for programme-makers generated by the often conflicting expectations of our adult viewers, raised on a diet of technically sophisticated general service broadcasting but schooled in a fairly traditional way. They want to be taught but they don't want boring television. Attempts to resolve this tension are not always successful, as we shall see.

However, there are instances in which the tension or conflict does not have to be faced. This is when a decision is taken to leave aside the strictly pedagogic functions and to design a programme intended to

provide a substitute experience. When the aim of such a programme is clear to students, and when they can see clearly the relevance of the experience to furthering their understanding or awareness of central themes of study, a highly successful learning outcome - impinging more on the affective than the cognitive domain - can be achieved. This was the case with programme six in the 'Handicapped Person' course, which focussed on 'The Wessex Experiment' and which had no strong didactic element: it simply expected students to watch, and to feel the quality of interactions between mentally handicapped children and untrained house-mothers.

A major problem often arises, however, when the tension between expectations about good professional broadcasting and about sharp pedagogic content or function are dealt with in a way which attempts to graft on a plausible academic rationale to a well-established, familiar broadcasting format. There are very many cases of this in the Open University programming. There is no model of television or radio programme construction unique to the Open University. To a large extent we have simply learnt and adopted the existing practices and conventions of general service broadcasting. There is no doubt that often, preoccupation with the achievement of good professional broadcast standards leads to an emphasis on the product - the programme itself - while the process - the learning process - risks being ignored, or at least taken seriously only when it is too late to be dealt with adequately.

One television format which is being increasingly used at the Open University is that of the documentary case-study. These programmes tend to present concrete examples of behaviour, drawn from the real world. They often contain very little or no academic commentary, and they can be used in a variety of ways; for example, to reflect the interrelation and complexity of various factors in structuring the behaviour or reality which they present. The programmes look very similar to the standard 'Horizon', 'World in Action' and so on. However, Open University documentary case studies tend to have associated with them elaborate sets of aims, generally related to the development of intellectual skills such as analysis, application, evaluation and so on.

Programme 10 of the 'Handicapped Person in the Community' is called 'Working Together'. Its theme is community effort in the provision of employment opportunities for handicapped people. However, it is not simply a programme about the provision of such employment. Its intention is to provide students with material on the basis of which they can evaluate the roles played by the various protagonists and relate them to attitudinal, social and economic factors discussed in the correspondence texts.

The problem with this type of programme, as we have established over and over again through research, is that the very familiarity of the format engenders an unconscious relaxation which can encourage an emotional, accepting response, and a sort of 'so what' reaction when it has ended. It must be said that at least some of the programmes simply cannot carry or justify the weighty educational aims attached to them, since they were actually conceived and produced with no such aim in mind. Often such programmes are made with only their particular contents as a reference frame. The way in which the content is to be used, the intellectual skills to be developed, and the way in which the programme is to structure knowledge -

in other words, the teaching functions - may be only very loosely defined. Educational aims and conceptual links may then at a very late stage of programme production be 'laid over' on already existing programme structure. Other case studies, although designed with academic integrity, are nevertheless unsuccessful because they are over-ambitious, demanding the application of intellectual and visual literacy skills which many students simply do not have.

We know very little about how to teach visual literacy skills. But there have been some interesting experiments on presentational features such as camera angle, presenter profiles, contrast, repetition, attention-directing techniques and so on. Going beyond that to the level of more fundamental coding factors, at the Open University we have identified five basic dimensions along which many of our programmes can vary: briefly, we describe these as didactic-open-ended, structured-unstructured, active-passive, neutral-polemical and integrated-freestanding. We argue that programmes should be placed along these dimensions according to the extent of students' experience in handling educational media material. We are also developing a package for the teaching of audio-visual literacy for use by people preparing for Open University study and have produced a number of programmes to demonstrate to students some of the skills involved in the use of broadcast material on certain courses.

Our researches have shown that in the vast majority of cases, students are unaware of not only the purely presentational features which can influence their perceptions of broadcast material, but also of the more fundamental factors which need to be considered when audio-visual material is used for certain purposes: factors such as the nature of the editorial process, the representativeness of the material presented, the role of the commentary and its relationship to the visual element and so on. The intellectual analysis - or even the critical viewing - of such material requires the development of a particular attitude to the media, as well as a particular battery of skills.

To return to our starting point: it seems to me that the question of whether people can learn from audio-visual media is hardly worth asking. That is not the problem. The problem is to ensure that what is intended to be learnt is learnt, and it is in the seeking and finding of possible solutions to this problem that I think research can make its major contribution.

DISCUSSION

Floor: The behaviour modification clip we saw was very slick and I felt that it was a really good production, so I cannot accept what you said about presentation not being important.

Miss Gallagher: I'm not saying that presentation doesn't matter at all, I'm just saying that there is often a danger in emphasising that aspect to the extent that what you're trying to do within the presentation tends to get left to one side. Obviously if the message is clear and simple then it is going to come over anyway, but trying to do something a bit more complicated, like developing higher order skills in the people who are watching, in a slick production is a little more difficult because of the fact that your're not simply putting over a straightforward message - you're wanting them to look at what they're seeing very critically. It's that intrusion of the production technique on the message and on the viewer that is often a source of conflict. But I wouldn't for a minute say that we have to go back to the kind of Open University programmes that we were making seven or eight years ago when people

were standing in front of a blackboard and pointing - that would be disastrous. Simply to bear in mind that what we are doing is to teach - we're not just making television programmes.

Floor: Can I just say that I think this is something which is reflected in life in the way that we view violence - Vietnam and so on. While we were seeing it there was a kind of immediacy but afterwards one had trouble to feel anything about it at all. How do you get the aims incorporated into the teaching itself without making them stand out like a sore thumb ?

Miss Gallagher: Yes. Another problem which arises with many of these programmes is when they deal with issues like that, people do become very involved with the issue rather than with what the issue is trying to represent. So that's another question of being able to distance the viewer from what he is actually seeing to enable him to analyse it. It's something which we've not really tackled very successfully, I would say, in our programmes but at least we're beginning to become aware of some of the problems that arise when we make that kind of presentation. The other thing of familiarity with an issue making it impossible actually to feel and to remember vital scenes is more of a problem with the format itself - with the documentary or case-study type format.

Floor: When you are doing your programmes would it not be better to list the aims beforehand ?

Miss Gallagher: There's a continuing debate about this in the University and there has been the feeling that this would be talking down to the students who are adults, many of them well qualified people - 'they should be able to deal with what is in the programme' - 'they're not going to want that approach.' We've found that that is really not so and we have now actually gone back to re-edit our social science foundation programmes so that each programme now has an opening caption which says: 'This programme is intended to do x, y or z'. But that took an enormous amount of effort to get through the production side of the University because of the initial reasoning against it of 'talking down'. When one tried to combat that the reaction was: 'Its a messy programme'; 'It doesn't look nice'; 'Its a much nicer package if the programme stands on its own'. So that's another side of the very thorny problem that programmes are going out over the network, they are being seen by millions of people. - For every one of our students who watch a programme, forty non-Open University people are watching, and among these are potential employers of Open University producers!

Floor: While the students are presumably adult, they are not professional students and so presumably the theories of teaching by objectives which stand in most other areas should be utilised as they have been found to be educationally viable elsewhere.

Miss Gallagher: Yes it does seem difficult to explain but when you think of the sorts of people who make the programmes, the producers in the main are not educationalists and tend to denigrate the objectives approach. And that is not just true of producers: many other people in the Open University feel that that approach is stagnant. There's that side to it but then there is also the argument that the objectives can be put in the associated material and this is usually what is done. The broadcast notes are used to carry that information which it is felt can be presented more adequately in print than it can be in the programme. But then we've got the problem of the integration of the print and the programme material and we don't know enough about how much people can carry over from one medium to another and can conceptually integrate while they're watching - its a very complicated process.

Miss Lee (BBC): I just wanted to confirm what Miss Gallagher is saying, that this runs right across the board with educational programmes. For example with the "Let's Go" series it was felt that if they were slowed down any further it would look odd when they were actually being transmitted. And although you could say they're not meant for ordinary viewers there is still this assumption that if something goes out over the network it must not look so strange to ordinary people.

Miss Gallagher: It would take a very brave producer to fight against that, I think. We have had some quite extraordinary programmes really - there was one from a psychology course which was designed to illustrate one of Eysenck's theories of personality. While students were actually watching the programme they had an electronic timer and were supposed to try to follow the spiral being shown and take timings and note them down. - A very complicated thing to do but the whole programme consisted of this thing going round and roung and round. There was a great deal of curfuffle about it: 'What is this going to look like when it goes out over the network?' It was justified because it was the only way that the experiment could be done, but that kind of thing is the exception rather than the rule in Open University programmes.

Floor: How far do producers evaluate the programmes that go out on general service for the information they impart? People who make "Tomorrow's World", "Panorama", "Horizon", - do they measure the amount of information that's taken in by the viewers ?

Miss Gallagher: There's no real evaluation of this kind but there is somebody working at the BBC at the moment on a study of News Bulletins - trying to measure how much people retain from a news bulletin. Its absolutely infinitesimal they've found - for example from a 20 minute bulletin they will remember about two key points - about 30 second's worth of information.

Floor: Well, you are keeping them informed of world events and although they retain it they can't actually give it back to you. You're still informing them of world events and if you d dn't give them the News then they would be missing something educationally, or they would feel they would be.

Floor: May I ask again this question of evaluation? - You say there are tensions between producers and teachers about the format of the programmes. Do you use your evaluation data to reconcile the situation? Because presumably the new programmes have measurements of the information imparted, or reactions. Is that data not a tool to argue with ?

Miss Gallagher: Yes, that's what our research group is supposed to be able to do, to evaluate the programmes and present that information. But there are a number of problems with it. - First of all, people don't generally listen to what we tell them, they only use it to further their own interests or ideas. I'm not completely cynical about it - I think it does have an impact over time and I believe that at the moment this debate we're having has only really got going because of the research that we've done. We've made it impossible for people to ignore the fact that there is a basic confusion among students between what they're seeing and what they're supposed to be doing with what they're seeing. So I think that it can help, but there is the enormous problem of covering all the programmes that we make. We're a small group and the OU is now putting out about 1400 different television programmes a year and about the same number of radio programmes. Therefore, there's a problem of selection of what is the best thing to look at and then of devising appropriate methods, which is not easy. But yes - it does have an impact, and I think that more than anything just talking to producers has an impact rather than the data itself.

Floor: Is it possible to get recordings of Open University programmes?

Miss Gallagher : Yes - all of our programmes can be bought but they are extremely expensive. However, they can be recorded for use within the educational field for a limited period - they come under the BBC copyright, so if you can record the programmes you can use them for educational purposes. The Open University itself doesn't have a copying system at the moment - we've been trying for years to get a video back-up service in our study centres so that people who miss programmes can watch them in the study centre, or that tutors who want to use them for discussion within a group can do so. But its very expensive indeed and we haven't decided yet to make the provision, but I'd say that if you haven't actually had a recording made, probably your only way of getting it now is to buy it.

Floor : There is a slight problem that technicians don't start work as early as some of the OU programmes are transmitted.

Floor : But you can record automatically on a video machine - set the timer.

Floor : Can I just add to that ? - I'm not sure if it exists in every region but our Regional Health Authority has a technician who we ring up if we want something recorded. Does this happen in other regions ?

Floor : No !

Miss Gallagher : Many university libraries and public libraries have cassettes of our tapes and there are some agreements between various institutions and the Open University which allow these places to copy. So you might be able to buy from these places, and that information would be very easy to get at.

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